EXPERIENCES OF DEPRESSION IN BLACK SOUTH AFRICAN YOUNG ADULT MEN IN THE WORKPLACE

By:

ROXANNE ZWART

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Supervisor: Dr Linda Eskell Blokland

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Declaration

I, Roxanne Zwart, hereby declare that this mini-dissertation, submitted for the partial fulfilment for the requirements of the Master of Arts degree in Counselling Psychology in the Faculty of Humanities at the University of Pretoria, is my own work. I further declare that, as far as is known, all sources have been duly acknowledged.

Roxanne Zwart

August 2020

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Abstract

Common Mental Disorders are a leading cause of disease burden in the world, with depression being in the top five. South Africa has significantly high rates of depression and suicide. Little research has been conducted on the experiences of depression in black South African young adult men, particularly in the workplace. Cultural and gender norms with regards to depression may have far-reaching consequences on the lives of black South African men. The objectives of this research was to explore how gender, culture, and the workplace influence black South African men's experiences of depression. Additionally, the risk of suicide, help-seeking behaviours, and factors which may lead to recovery within this population were explored. The research is situated in a qualitative methodology, using an interpretive paradigm, and a phenomenological study was conducted. The researcher used interpretive phenomenological analysis (IPA) on transcribed semi-structured interviews. The study included three participants, who were black South African males aged 32 to 38 years old and working in urban Gauteng, and who had a diagnosis of depression from a healthcare professional within the last two years. The findings revealed that depression, culture and the workplace had a profound impact on their experience and expression of depression. The participants also struggled within their workplaces while experiencing depression and their ability to work was thus severely impacted which resulted in negative consequences. Furthermore, the participants all struggled with suicidal ideation. The factors which led to recovery were also reported on so that we may gain a deeper understanding of what did help the participants in order to be better equipped to assist others and obtain a better understanding of successful treatment within this population.

Key Terms: culture; depression; interpretive phenomenological analysis; male gender; recovery; South Africa; workplace; young adults.

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Chapter 1

Introduction

Research Problem

Common Mental Disorder's (CMDs) are a leading cause of disease burden in the world, with depression being in the top five (Akyeampong, Hill, & Kleinman, 2015). Globally, depression is predicted to be the first common cause of disability by 2040, and approximately 60% to 70% of suicides are completed by people who suffer from depression (Reddy, 2012). In a South African Stress and Health (SASH) study, it was estimated that in South Africa depression had among the highest lifetime prevalence rates, at 9.8 percent (Mungai & Bayat, 2019). Little research has been conducted on the experiences of depression in black South African young adult men, particularly in the workplace. The impact of depression may have several negative consequences in those whom it affects and these may be disabling and may lead to suicide.

These consequences have a far-reaching impact within the communities and societies where individuals with depression function and little is known within this population about their experiences. Feelings of hopelessness, worthlessness, and sadness are often used to define depression (Hamad, Fernald, Karlan, & Zinman, 2008; Mungai & Bayat, 2019). In order to understand the concept of depression within this research, the diagnostic criteria from the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Major Depressive Disorder (MDD) is used.

Depression can occur in any gender, race, and culture, for a variety of reasons. Literature addressing men and depression reveals two important themes – their symptoms and experiences differ from traditional mood presentations and men are less likely to report their

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symptoms because the symptoms are at odds with ideals of masculinity and social constructions of gender roles (Martin, 2010; Martin, Neighbors, & Griffith, 2013). In a study conducted by Martin et al. (2013) it was found that gender likely plays a role in how people conceptualise and experience depression - men, in general, were significantly more likely to report symptoms of aggression, irritability, substance abuse and risk-taking behaviours. Furthermore, men's experiences of depression may manifest with symptoms that are not included in the current diagnostic criteria (Martin et al., 2013). In contrast, research from the American Psychiatric Association [APA] (2013) shows major depressive disorder has a higher prevalence in females but there are no clear differences between genders in symptoms, course, treatment response, or functional consequences. Furthermore, in South African communities there is a tendency to view the main cause of disorders, such as depression, as having a weak character, and are less likely to seek help (Austin, 2012).

Studies have since shown that depressive symptoms and the risk of depression are quite significant within African communities. Major depressive disorder (MDD) is a common mental disorder and one of the three leading causes of disease burden in South Africa (Nglazi et al., 2016). Major depressive disorder is a debilitating disease that involves clear cut changes in mood, interests, and pleasure, as well as cognition and vegetative symptoms (Otte et al., 2016). It is unclear as to whether black South African men experience these symptoms as outlined in the DSM-5, as several factors impact their experience of symptoms. The DSM and other conventions of evaluating and assessing diagnosis make attempts to capture the essence of a mental health disorder, however, it may be difficult to interpret symptoms through the filter of language and cultural bias (Awaad & Reicherter, 2016). Of importance is that there is little consensus on the extent to which these cultural factors influence psychiatric disorders (Awaad & Reicherter, 2016). However, although not all people will display the same symptoms, there are core clinical features found across all cultures (such as

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somatic discomfort and guilt) (Austin, 2012). It should be noted that despite these commonalities, there are potential limitations in using DSM-5 criteria as social isolation, crying, anger, and general pain, which were commonly mentioned features which are not included in the DSM (Mayston et al., 2020). Mayston et al. (2020) state that it is essential for researchers and practitioners to be fluent in local conceptualisations of depression for detection to be meaningful and that sticking strictly to the DSM diagnosis will limit detection due to relevance (Mayston et al., 2020). It would, therefore, be advantageous to investigate African culture and how depression is understood and conceptualised within this population.

South Africa has approximately 52 million people with many different cultural beliefs, languages, and religions – of this number nearly 79.2% are Africans while the DSM is mostly created on disorders which are based on American mental health professionals' patient population (Kriegler & Bester, 2014). The concept and label of depression was developed in the west and it fits and suits Western culture, whereas traditional African culture has not concretised or labelled depression (Ellis, 2008). Studies in South Africa assessing attitudes toward mental illness have found that there is a stigma surrounding the mentally ill and there are misunderstandings with regards to the causes of mental illness (Hamad et al., 2008).

These symptoms and understandings, together with the cultural and gender norms, may have far-reaching consequences on the lives of black South African men who experience depression, such as in the workplace – where many individuals tend to spend the majority of their time. Depression in the workplace is explored as one of the central aspects due to the high depression prevalence rates found within workplaces.

Black men make up 42.8% of the South African workforce (Watkins, 2017). Recent studies on employed South African people found a prevalence of depression of 18.3%, and an additional 16% who were unsure of whether or not they had depression (Andersson et al.,

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2013). Other recent research in the South African workforce found that at least one in four employees have been diagnosed with depression and that the age group of 25 – 44-year-olds are most affected (Stander, Bergh, Miller-Janson, De Beer, & Korb, 2016). Work can be stressful and when employees receive negative feedback and have decreased self-esteem, this may add to their stress levels and lead to disability, suicide attempts, and job loss (Woo & Postolache, 2008). Occupational stress and interpersonal problems can also trigger depression (Stockenstroom, 2018). Many men spend most of their day at work, so it would be further beneficial to investigate both how this population understands depression and how it may impact on their work, and how their work may impact on their depression. Furthermore, how depression may impact productivity and the implications thereof in broader contexts. Individuals may have an impaired ability to think, concentrate, or make decisions and may appear easily distracted or complain of memory difficulties - those engaged in cognitively demanding pursuits are often unable to function (APA, 2013; Sadock, Kaplan, Sadock, & Ruiz, 2016).

Although depression is highly prevalent, with a definite social and economic impact in South Africa, Government does not spend enough on adequate treatment of mental illness and it costs South Africa 2.2 percent of its annual GDP, which equates to the total annual cost to the country in lost earnings at R40.6 billion as far back as 2003 (Bateman, 2015; Tomlinson et al., 2016). Workplace depression has far-reaching consequences on societies and it would be beneficial to manage workplace depression and assist employees in this regard. Due to the negative consequences of depression within the workforce, it would be essential to promote mental health wellness and assist in understanding the factors which impact help-seeking behaviours and which influence effective treatment. Delays in treatment may worsen the depression and further complicate later recovery or lead to death by suicide.

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Depression is the leading cause of death by suicide worldwide and half of all completed suicides are related to depressive and other mood disorders (Silke, 2018). Globally suicide is the third leading cause of premature mortality in people aged 15 – 44 years old, and in 2015, 78% of suicides were completed in low-and middle-income countries (LMIC) (Silke, 2018). Suicide is a serious public health problem in LMIC's and understanding context and gender-specific risk factors will assist in creating interventions to reduce suicide (Bantjes et al., 2018). Individuals with a previous history of suicide attempts or threats, male sex, being single or living alone, alcohol dependence or misuse and having prominent feelings of hopelessness are at higher risk of suicidal behaviour, although the possibility of suicidal behaviour exists at all times during major depressive episodes (APA, 2013; Isometsä, 2014). These risks are important to understand and investigate within this population so we may be in a better position to assist and prevent the risk of suicide. Studies show that approximately 80 percent of suicides in South Africa are male, with hanging and poisoning being reported as the most common methods (Bantjes et al., 2018; Kootbodien, Naicker, Wilson, Ramesar, & London, 2020). The highest suicide rates in South Africa were also found to be in men aged 15 - 44 years old (Kootbodien et al., 2020). According to a 2014 report by SADAG, there are 4.6 male suicides for every female one in South Africa, and there are 23 completed suicides every day in South Africa, furthermore, 11% of all non-natural deaths in the country are due to suicide (Bateman, 2015; Van Niekerk, 2016). Underreporting of suicide was noted in South Africa, the quality of death certificates was the main limiting factor, which could result in an underestimation of true mortality burden attributable to suicide (Kootbodien et al., 2020).

In conclusion, there is limited research on the experiences of depression in men in South Africa and specifically black South African men in the workplace. Depression may, among other concerns, lower quality of life and affect socio-economic prosperity (Andersson et al., 2013). Untreated depression imposes a range of costs on individuals, households,

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employers, and society as a whole - due to depression being a lead cause of disability worldwide (Dawson, Tylee, & World Health Organization, 2001; Dowrick, 2004). The experiences surrounding depression concerning gender, culture, and workplaces are, therefore, essential to explore so we may gain further insight and understanding and be in a better position to understand and assist black South African men when it comes to mental health, and in particular, depression.

Aims and Objectives of the Study

The study aimed to investigate the experiences of depression in black South African young adult men in the South African workplace. The objectives of the research were to explore how gender, culture, and the workplace influence black South African men's experience of depression. Additionally, the risk of suicide, help-seeking behaviours, and factors which may lead to recovery within this population were explored.

Research Design and Methodology

The research is situated in a qualitative methodology in order to gather information on how young adult black South African men experience depression in the workplace, using an interpretive paradigm, and making sense of people's experiences by listening to them. Due to the nature of the study, a phenomenological study was conducted. The study had an aim of understanding lived experiences, therefore, the researcher used interpretive phenomenological analysis (IPA). IPA accepts that it is not possible to gain direct access into a participant's world, and even though the aim was to explore the participant's experience from his or her view, the exploration included the researcher's own world view and the nature of the interaction between the researcher and participant (Willig, 2013). This study included

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three participants who were black South African males aged 32 to 38 years old and working in urban Gauteng, who had a diagnosis of depression from a healthcare professional.

IPA works with transcripts obtained from semi-structured interviews (Willig, 2013). Non-directive interviews were conducted at a mutually decided venue and lasted for approximately an hour. The interviews were then transcribed and analysed. The researcher used a series of steps that allowed themes to be identified and integrated into meaningful clusters, first within and then across cases (Smith & Eatough, 2007; Willig, 2013). Each individual case was analysed by the researcher according to the following suggested steps (Storey, 2007; Willig, 2013):

1. Reading and re-reading the text: In this step initial thoughts and observations were recorded in response to the text.
2. Themes were identified and labelled as characterised by each section of text: These themes are conceptual and captured the essential quality of what was being represented by the text.
3. An attempt to introduce structure into the analysis: The themes from step 2 were identified and thought about in relation to one another- some themes formed natural clusters, while others had hierarchical relationships with one another. Clusters of themes were given labels to capture their essence.
4. The production of a summary table of structured themes, together with quotations to illustrate each theme: The themes capture the participant's experience of the phenomenon under investigation, therefore some themes were excluded. The summary table includes cluster labels together with subordinate theme labels, quotations and references to where extracts are found in the transcript.
5. Themes were integrated across transcripts to identify shared themes and capture the essence of the participant's experience.

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An Overview of the Study

Chapter one provides an introduction to the study and an overview of the dissertation. Chapter two presents an overview of both national and international literature and studies done with regards to key elements within this study. As such, depression is explored with regards to culture, gender, the workplace, and the risk of suicide. Chapter three focusses on the methodological nature of this research. It provides a detailed discussion of the qualitative approach to this research, as well as the phenomenological approach. Further, it includes data collection procedures and inclusion criteria as well as data analysis methods. The procedure for the Interpretive Phenomenological Analysis of the data is presented and illustrated. The ethical considerations of this research are also presented. Lastly, my researcher positionality statement is included. Chapter four presents the summary of themes and findings from the transcribed data, which include verbatim extracts. The findings are presented in light of the research question and include four main themes and 13 sub-themes. Chapter five presents an integrated discussion with regards to the findings. The expressions and experiences of depression are discussed with regards to cultural and gender aspects and depression in the workplace is explored. This section also reports on the findings related to suicidal ideation and risk. The chapter includes a discussion on the factors which led to recovery within this population. The limitations of this study and recommendations developed through the course of this research are commented on and a final conclusion is presented. Lastly, the researcher's reflections are presented.

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Chapter 2

Literature Review

This review of the literature follows on the introduction. The introduction outlined the need for research to be conducted in South Africa with regards to the experiences of depression in young adult black South African working men. This review covers some of the core literature on depression, as is relevant to the research question. The review outlines the main contours of depression with regards to the gender and the cultural aspects thereof as well as depression in the workplace and the implications of untreated depression within this population.

There are several factors to consider in this research which include gender, culture, and the workplace and how they impact the black South African male in his experience with depression. The first section attends to major depressive disorder and gender, which is one of the central concepts of this study.

Depression and Gender

In order to gain an understanding of depression and how it manifests when certain factors -such as masculinity- are considered, it is important to understand how depression is globally defined and understood. Understanding how men experience depression may assist us in understanding causes and guide treatment. Furthermore, it is important to note that literature reveals that men do not typically present with traditional mood presentations and that they are less likely to seek help. This would negatively impact the ability to identify depression and assist in treatment.

Common Mental Disorders (CMDs) are a leading cause of disease burden in the world, with depression being in the top five (Akyeampong et al., 2015). Globally, depression

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is predicted to be the first common cause of disability by 2040, and approximately 60% to 70% of suicides are completed by people who suffer from depression (Reddy, 2012). In a South African Stress and Health (SASH) study, it was estimated that in South Africa depression had among the highest lifetime prevalence rates, at 9.8 percent (Mungai & Bayat, 2019). The impact of depression may have several negative consequences in those whom it affects and these may be disabling and may lead to suicide.

Impairment from major depressive disorder varies amongst individuals and ranges from mild impairment (those who interact with the individual are unaware of the depressive symptoms) to incapacity (the individual is unable to attend to basic self-care needs, is mute or catatonic), and are usually classified as mild, moderate and severe (APA, 2013; Mungai & Bayat, 2019). Depression may be a single episode or reoccurring and the impact of depression on an individual's quality of life is dependent on the severity (Mungai & Bayat, 2019; Sadock et al., 2016). Some individuals may be unaware of their depression and do not complain of mood disturbances even when they withdraw from people close to them and from activities they had previously enjoyed (Sadock et al., 2016). In general medical settings, individuals with major depressive disorder have more pain and physical illness and greater decreases in physical, social, and role functioning (APA, 2013).

These consequences have a far-reaching impact within the communities and societies where individuals with depression function and little is known within this population about their experiences. Feelings of hopelessness, worthlessness, and sadness are often used to define depression (Hamad et al., 2008; Mungai & Bayat, 2019). In order to understand the concept of depression within this research, the diagnostic criteria from the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Major Depressive Disorder (MDD) will be introduced.

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A diagnosis of MDD is made on the assessment of clinical presentation (five out of nine symptoms present), history (symptoms last more than 2 weeks), and relevance (significant distress or impairment in functioning) (American Psychiatric Publishing, 2014). A diagnosis includes low mood and anhedonia, a change in sleep patterns, altered eating habits, loss of libido, psychomotor changes, loss of concentration or indecisiveness, loss of energy, guilt feelings or loss of self- esteem and suicide ideation or suicide attempt (Baumann, 2015; Dowrick, 2004). It should be noted that often fatigue or insomnia is the presenting complaint, and some individuals may focus on a somatic complaint (American Psychiatric Publishing, 2014; Sadock et al., 2016). Depression can occur in any gender, race, and culture, for a variety of reasons. Furthermore, these factors may influence the way in which each individual experiences depression, particularly with regards to gender. Additionally, men and women conduct themselves differently within societal norms and this has an impact on how they express themselves.

Literature addressing men and depression reveals two important themes – their symptoms and experiences differ from traditional mood presentations and men are less likely to report their symptoms because the symptoms are at odds with ideals of masculinity and social constructions of gender roles (Martin, 2010; Martin et al., 2013). Due to masculinity having several meanings and within the parameters of this research, hegemonic masculinity is identified.

Hegemonic masculinity is a set of values established by men in power in order to organise society in gender unequal ways, which includes the interplay between men's identity, men's ideals, interactions, power and patriarchy (Jewkes, 2015). Martin et al. (2013) state that men's responses to a depressed mood or sadness are shaped by their adherence to or rejection of hegemonic masculinity and that gender socialisation may restrict emotional expression leaving men with limited ways in which to express their psychological distress. Gender

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differences with regards to expressing emotions reveal that women tend to express 'vulnerable' emotions such as sadness while men show more 'powerful' emotions such as anger, therefore men may consequently report fewer depressive symptoms (Kunst, de Groot, & van der Does, 2019). In a study conducted by Martin et al. (2013) it was found that gender likely plays a role in how people conceptualise and experience depression - men, in general, were significantly more likely to report symptoms of aggression, irritability, substance abuse and risk-taking behaviours. Furthermore, men's experiences of depression may manifest with symptoms which are not included in the current diagnostic criteria (Martin et al., 2013). In contrast, research from the APA (2013) shows major depressive disorder has a higher prevalence in females but there are no clear differences between genders in symptoms, course, treatment response, or functional consequences. There are therefore contradictory claims about the experiences of depressive symptomology with regards to gender which need to be further investigated. Men may be hesitant to disclose their symptoms in order to conform to their societal standards and it may alter the ways in which men experience and express their depression, several studies have been conducted with regards to this and further indicate contradictory findings.

The World Health Organisation conducted a study of mental illness in primary care and found that female rates of CMDs were almost double those of men, however, considerable variation was found across centres which suggested a cultural basis for this variation (Akyeampong et al., 2015). In South Africa, the estimated depressive symptomology is 36 percent for women and 27 percent for men, which indicates a potentially high burden in this population (Adjaye-Gbewonyo, Avendano, Subramanian, & Kawachi, 2016). The lower depressive symptomology may be due to several reasons, one of which could be due to men expressing themselves differently than women. In Nigeria, the diagnosis of current CMD was more common in men (5.3 percent) than women (3.8 percent) (Akyeampong et al., 2015).

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Another study conducted by Andersson et al. (2013) on the prevalence of depression in the Eastern Cape Province among individuals aged 18 – 40 showed no gender differences in the prevalence of depression. It would, therefore, be useful to study the impact that gender has on the experiences of depression to identify whether men display typical symptoms, as proposed by the APA, despite it being more prevalent in women in some studies.

Furthermore, in South African communities there is a tendency to view the main cause of disorders, such as depression, as having a weak character, and are less likely to seek help (Austin, 2012). For men, this is further compounded as men may have a lower mental health literacy than women and traditional masculine norms and stigma associated with mental illness, which may promote a culture whereby men are reluctant to acknowledge or seek help as this may be seen as a sign of weakness (Roche et al., 2016; Watkins, Walker, & Griffith, 2010).

In addition to the traditional masculine norms that black South African men may be following, there are cultural norms that may also be impacting them and which will be discussed in the following section, highlighting another important concept within this research.

Depression and Culture

Due to South Africa being culturally diverse, it is important to identify what is meant by culture within this research before discussing depression and culture. Culture is environmentally acquired and contains beliefs, principles, standards, activities, and symbols which reflect societal experiences conveyed cross-generationally (Wagner & Hassim, 2013). When African culture is discussed, it is not presupposing that all Africans have the same explanations for events, languages or dress mode, but rather that there are underlying similarities in African culture (such as dominant traits in their belief systems and similar

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values) which reveal large differences when contrasted with other cultures (Idang, 2015). In particular, when contrasted with western cultures, such as the USA, and how MDD presents within these cultures.

In Africa, the prevalence of mental illness in general remains underestimated and was historically thought to be rare or non-existent (Hamad et al., 2008). Studies have since shown that depressive symptoms and the risk of depression are quite significant within African communities. In a South African study conducted by Adjaye-Gbewonyo et al. (2016), it was found that the African population group had higher depressive symptoms when compared to other population groups. Other studies have had similar findings with black African individuals having higher odds of depression risk when compared to other groups (Burns, Tomita, & Lund, 2017). Just as gender plays a role in the identity and experiences of men, culture may have an equal impact. Mental health disorders in South Africa are common and due to the diversity in the country, it is important to understand the cultural manifestations thereof.

Major depressive disorder (MDD) is a common mental disorder and one of the three leading causes of disease burden in South Africa (Nglazi et al., 2016). The symptoms of depression may have a significant impact on those who are affected and this filtrates into several areas of an individual's ability to function. As previously mentioned, the criteria discussed in the DSM-5, that need to be met within the two week period include depressed mood, diminished interest in activities, changes in behaviour, appetite, sleep, fatigue, diminished cognitive abilities, demeaning thoughts of self and thoughts of self-harm or death (APA, 2013). Furthermore, these symptoms are not attributable to another condition or other factors and cause significant impairment in an individual's ability to cope and in important areas of functioning (APA, 2013). Major depressive disorder is a debilitating disease that involves clear cut changes in mood, interests, and pleasure, as well as cognition and vegetative

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symptoms (Otte et al., 2016). It is unclear as to whether black South African men experience these symptoms as outlined in the DSM-5, as several factors impact their experience of symptoms. Critical psychiatrists have argued that social conditions contribute to mental disorders, which are described as patterns of behaviour expressed during interpersonal and social interactions, and thus do not simply occur in individuals (Middleton & Moncrieff, 2019).

The DSM and other conventions of evaluating and assessing diagnosis make attempts to capture the essence of a mental health disorder, however, it may be difficult to interpret symptoms through the filter of language and cultural bias (Awaad & Reicherter, 2016). Earlier studies conducted in Africa have revealed that people may not seek help for their mental illness because they may not be aware that it is treatable, or that they may recover without treatment, not knowing where to go or feeling embarrassed, as well as beliefs that mental illness is a somatic illness (Andersson et al., 2013). These studies suggest that with regards to depression and culture, it concerns educating and informing African communities about depression and reducing stigma in order to assist in diagnosis and treatment. Therefore, social and political interventions are required if the burden of mental disorder is to be reduced (Middleton & Moncrieff, 2019). South Africa has a very diverse population and due to the scarce studies conducted on the experiences of depression in black South African men, it is also unclear how much culture would impact and affect their experiences of depression.

Western academic psychology has a tendency to assume a universalistic cultural context which has led to a diminished importance of non-Western cultural considerations in psychology, and there is evidence that a person's cultural background influences the ways in which they experience illness from linguistic structure to uniquely expressed emotions (Awaad & Reicherter, 2016). Of importance is that there is little consensus on the extent to which these cultural factors influence psychiatric disorders (Awaad & Reicherter, 2016).

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However, although not all people will display the same symptoms, there are core clinical features found across all cultures (such as somatic discomfort and guilt) (Austin, 2012). In addition, depressed mood or sadness, fatigue or loss of energy, and sleep problems were identified as the most common features in both non-Western and Western populations in a systemic review of qualitative evidence by Haroz et al. (Mayston et al., 2020). It should be noted that despite these commonalities, there are potential limitations in using DSM-5 criteria as social isolation, crying, anger, and general pain were commonly mentioned features which are not included in the DSM (Mayston et al., 2020).

Understanding psychopathological symptoms are varied across communities, with the Western view of mental illness receiving the most interest, despite the acknowledgement of culture being important and that diagnosis and experiences of psychopathologies may not be constant (Wagner & Hassim, 2013). An important aspect of understanding psychopathology according to culture is the psychoplastic effect, whereby culture influences the expression of psychopathology (Wagner & Hassim, 2013). The expression of disorders and the presentation of symptoms varies across cultures (Kriegler & Bester, 2014). Studies have shown that western societies ascribe the causes of mood disorders to internal states, whilst non-western societies tend to ascribe the causes to external forces such as social conflict, envy, witchcraft, or sorcery (Austin, 2012). Feelings of sadness or distress may be referred to as in terms such as having a "heavy spirit", "difficulty breathing" or being oppressed by others (Baumann, 2015). Due to the many factors which impact an individual, and particularly cultural factors, investigating depression while considering culture will give a deeper understanding of mental illness across cultures. Mayston et al. (2020) state that it is essential for researchers and practitioners to be fluent in local conceptualisations of depression for detection to be meaningful and that sticking strictly to the DSM diagnosis will limit detection

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due to relevance (Mayston et al., 2020). It would, therefore, be advantageous to investigate African culture and how depression is understood and conceptualised within this population.

As previously stated, in many cultures somatic complaints are likely to constitute a presenting complaint – insomnia and loss of energy are the most uniformly reported (APA, 2013). Important findings of studies in Africa have found that core symptoms of CMDs can be detected similarly in most cultures, with presenting complaints being predominantly somatic, however, this does not exclude emotional or cognitive experiences, which may not be as readily volunteered to treating health care providers (Akyeampong et al., 2015). Depression has also been conceptualised as a problem relating to worrisome thoughts about psychosocial problems rather than emotions like sadness and it was therefore perceived that it did not require Western medication but rather an appropriate solution was to seek lay help from social groups, such as religious groups, friends, traditional healers or relatives (Akyeampong et al., 2015). Studies have highlighted that Zulu people (in South Africa) found Western medicine useful for treating physical illness and not mental illness, because mental health problems were considered to be only understood by traditional healers within the same culture (Andersson et al. 2013). South Africa has approximately 52 million people with many different cultural beliefs, languages, and religions – of this number nearly 79.2% are Africans while the DSM is mostly created on disorders which are based on American mental health professionals' patient population (Kriegler & Bester, 2014).

Research is discovering that depression in black Africans is underdiagnosed as it presents in different ways of living and interacting and from a different world view (Ellis, 2008). It may be possible that black South African men experience depression in slightly different ways and this would be essential to investigate if we are to assist and alleviate the burden of mental disorders within this population. In some South African cultures, depression appears to be less tolerated or understood than in other cultures and this may hinder treatment.

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Kriegler and Bester (2014) state that more progress is needed in culture-sensitive research and in understanding the dynamic relationship between biological and sociocultural influences within psychopathology. As discussed earlier, the way people conceptualize depression varies widely cross-culturally, and it is important to note that language and cultural barriers exist in terms of perceiving and interpreting depression (Austin, 2012; Hails et al., 2012).

Every culture has personalized knowledge with regards to the perception and interpretation of illness, and understanding these manifestations can inform us about the origins and possible treatments for abnormal behaviour (Barlow & Durand, 2005; Wagner & Hassim, 2013). The concept and label of depression was developed in the West and it fits and suits Western culture, whereas traditional African culture has not concretised or labelled depression (Ellis, 2008). Local culture and religion have a profound impact on people's lives, particularly in poor resource settings where common barriers are stigma and misconceptions about mental illness (Andersson et al., 2013).

Studies in South Africa assessing attitudes toward mental illness have found that there is a stigma surrounding the mentally ill and there are misunderstandings with regards to the causes of mental illness (Hamad et al., 2008). Words like depression do not translate readily into other cultures and many languages do not have the equivalent for this concept and it remains diffuse and undifferentiated (Dowrick, 2004; Ellis, 2008). Further, cultures and languages are constructed in such different ways that the concept of depression may be meaningless (Dowrick, 2004).

Cassey Chambers, who is the operations director from the South African Depression and Anxiety Group, stated that the stigmatization of anxiety and depression in the black South African community is "huge" and found that African culture and language were not always familiar with mental health concepts, for example, there was not an isiZulu word for

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depression (Van Niekerk, 2016). Kriegler and Bester (2014) further state that among some of the challenges when conducting research in Africa is “translating a complex psychological inventory into a Native African language”, and that there are different cultural norms as far as deviation goes and culture plays a significant part in the concept of self (p. 396). It would be particularly essential within a diverse country, such as South Africa, where different cultural norms are experienced and this may be conflicting to individuals – particularly with regards to mental disorders.

These symptoms and understandings, together with the cultural and gender norms, may have far-reaching consequences on the lives of the black South African men who experience depression, such as in the workplace – where many individuals tend to spend the majority of their time. Depression in the workplace is explored as one of the central aspects due to the high prevalence rates found within workplaces.

Depression in the Workplace

Depression in the workplace is important to consider in this research due to the high numbers of depression found within this population, as well as the negative consequences thereof, which be further discussed in this section. Black men make up 42.8% of the South African workforce (Watkins, 2017). Recent studies on employed South African people found a prevalence of depression of 18.3%, and an additional 16% who were unsure of whether or not they had depression (Andersson, 2013). Other recent research in the South African workforce found that at least one in four employees have been diagnosed with depression and that the age group of 25 – 44-year-olds and females are most affected (Stander et al., 2016). Additionally, fifty percent of all patients have an onset of depression between the ages of 20 and 50 years (Sadock et al., 2016). This shows that young adults are among those most affected.

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Adulthood is sometimes divided into 'young adulthood', which is roughly the ages of 19 to 34, and this is a critical life stage which involves decisions about career (Suvisaari et al., 2009). Furthermore, studies show that there is a particular need to target mental health issues in working men (Roche et al., 2016). Work can be stressful and when employees receive negative feedback and have decreased self-esteem, this may add to their stress levels and lead to disability, suicide attempts, and job loss (Woo & Postolache, 2008). Occupational stress and interpersonal problems can also trigger depression (Stockenstroom, 2018). With such significant numbers of depression within this population, it would be beneficial to investigate the experiences of depression within this age group of working individuals and their experiences of both stressors and support within these environments. There may be several stressors which may negatively impact an individual's mental health and lead to depression.

Financial challenges, recession, and job shortages put a strain on employee's mental health and this is further complicated when aspects important to livelihood and identity (such as earning an income) are threatened and this heightens the risk of someone getting depressed (Govender, 2017). Urban areas are also associated with higher rates of depression than rural areas (Ajaero, Nzeadibe, & Igboeli, 2018; McKenzie, Murray, & Booth, 2013). These are not the only risk factors to consider in the development of depression. Certain factors can predispose someone to developing depression, such as high amounts of environmental stress and a lower socioeconomic level (Ahmed & Bhugra, 2006). Although there are several other factors that are implicated, these two alone could account for the prevalence of depression in the black South African community (SADAG, 2016). The stress from work and the environment may also make depressive symptoms worse, which negatively impacts performance and thus increases depression in an individual (Govender, 2017). It is important

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to gain a deeper understanding of these factors and how they are experienced, as well as the negative consequences of having depression and the reciprocity of these factors.

Many men spend most of their day at work, so it would be further beneficial to investigate both how black South African men understand depression and how it may impact on their work, and how their work may impact on their depression (how depression is experienced). Furthermore, how depression may impact productivity and the implications thereof in broader contexts.

Most research has been done in Western, high-income countries and little is known about the relationship between depression and workplace productivity varying across countries, except that the impact of depression in the workplace is considerable across all countries (both in monetary terms and related to the county's GDP) (Evans-Lacko & Knapp, 2016). According to Prof. Crick Lund of the Department of Psychiatry and Mental Health at UCT, the average figure for people to experience an inability to work or conduct day-to-day activities is an average of 27 days per a year for depression (Bateman, 2015). There are further negative consequences of depression within the workplace even when the individual physically attends work.

Individuals may have an impaired ability to think, concentrate, or make decisions and may appear easily distracted or complain of memory difficulties - those engaged in cognitively demanding pursuits are often unable to function (APA, 2013; Sadock et al., 2016). Additionally, 97% of depressed patients complain about reduced energy, have difficulty finishing tasks have less motivation for tasks, and are impaired at work (Sadock et al., 2016). This may have several negative consequences on the well-being and job security of men in the workforce. Blaming oneself for being sick and failing to meet occupational or interpersonal responsibilities is a common result of depression which exacerbates the situation

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(APA, 2013). Depression in the workplace, therefore, has considerable negative consequences for the individual and in broader contexts.

Although depression is highly prevalent, with a definite social and economic impact in South Africa, Government does not spend enough on adequate treatment of mental illness and it costs South Africa 2.2 percent of its annual GDP, which equates to the total annual cost to the country in lost earnings at R40.6 billion as far back as 2003 (Bateman, 2015; Tomlinson et al., 2016). Workplace depression has far-reaching consequences on societies and it would be beneficial to manage workplace depression and assist employees in this regard. It would require a supportive environment and an understanding of help-seeking behaviours. As previously mentioned, gender differences may be due to men being less likely to seek help. Furthermore, non-disclosure of depression as a reason for sick leave was predominantly due to stigma and work security issues (Stander et al., 2016). In a study done by the South African Depression and Anxiety Group, a significant proportion of respondents believed that their employer would not know how to support them with this (Stander et al., 2016). The possibility of men not seeking assistance within work environments may further compound depression. Additionally, stigma may hinder an individual from seeking assistance or help for mental health difficulties.

The stigmatisation of depression by both lay and medical populations is entrenched in Western culture (Dawson et al., 2001). It will be beneficial to investigate the degree, if any, that stigmatisation of mental health has within African populations and to investigate ways in which the stigma may be reduced. In other studies, it was found that stigma was diminished when people (men and women) made contact with others and shared their mental health diagnosis; furthermore, they reported personal empowerment and a better quality of life (Corrigen et al., 2016). Due to the negative consequences of depression within the workforce, it would be essential to promote mental health wellness and assist in understanding the factors

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which impact help-seeking behaviours and which influence effective treatment. Delays in treatment may worsen the depression and further complicate later recovery or lead to death by suicide.

Risk of Suicide

Untreated depression is associated with a high mortality rate which may lead to attempted or completed suicide (APA, 2013). Depression is the leading cause of death of suicide worldwide and half of all completed suicides are related to depressive and other mood disorders (Silke, 2018). Thoughts of death, suicide ideation, and attempts are common and range from passive (not wanting to wake up in the morning) to severe (having a specific suicide plan) (APA, 2013). The motivations for suicide can include a desire to give up (perceived insurmountable obstacles), wanting to end what is perceived as a constant painful emotional state, the inability to foresee any enjoyment in life, or the wish to not be a burden to others (APA, 2013).

Approximately 800 000 people a year die from suicide worldwide and it is estimated that up to 50% of these suicides occur within a depressive episode (Silke, 2018; Otte et al., 2016). In addition, up to one-half of all people who die by suicide do so in their first attempt (Isometsä, 2014). Globally suicide is the third leading cause of premature mortality in people aged 15 – 44 years old, and in 2015, 78% of suicides were completed in low-and middle-income countries (LMIC) (Silke, 2018). Furthermore, in the last 45 years, it has risen by 60% globally, with Western countries showing a decrease in their numbers over the same period (Silke, 2018). Suicide is a serious public health problem in LMIC's and understanding context and gender-specific risk factors will assist in creating interventions to reduce suicide (Bantjes et al., 2018). South Africa is an African and LMIC country, which places the country and this age group at high risk with regard to suicide statistics.

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Individuals with a previous history of suicide attempts or threats, male sex, being single or living alone, alcohol dependence or misuse and having prominent feelings of hopelessness are at higher risk of suicidal behaviour, although the possibility of suicidal behaviour exists at all times during major depressive episodes (APA, 2013; Isometsä, 2014). These risks are important to understand and investigate within this population so we may be in a better position to assist and prevent the risk of suicide.

Studies show that approximately 80 percent of suicides in South Africa are male, with hanging and poisoning being reported as the most common methods (Bantjes et al., 2018; Kootbodien et al., 2020). The highest suicide rates in South Africa were also found to be in men aged 15 to 44 years (Kootbodien et al., 2020). According to a 2014 report by SADAG, there are 4.6 male suicides for every female one in South Africa, and there are 23 completed suicides every day in South Africa, furthermore, 11% of all non-natural deaths in the country are due to suicide (Bateman, 2015; Van Niekerk, 2016).

It is important to note that suicide is not reliably counted in most developing countries and may not be a useful indicator of mortality (Akyeampong et al., 2015). In South Africa, the quality of death certificates was the main limiting factor, and underreporting of suicide was noted, which could result in an underestimation of true mortality burden attributable to suicide (Kootbodien et al., 2020). Any risk to life and well-being should be considered as essential to investigate and remedy, and therefore it is important that we investigate the consequences of untreated depression, as well the risk of suicide within this population.

Conclusion

In conclusion, little attention has been given to researching depression which, among other concerns, lowers quality of life and affects socio-economic prosperity (Andersson et al., 2013). Untreated depression imposes a range of costs on individuals, households, employers,

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and society as a whole - due to depression being a lead cause of disability worldwide (Dawson et al., 2001; Dowrick, 2004). The experiences surrounding depression concerning gender, culture, and workplaces are therefore essential to explore so we may gain further insight and understanding and be in a better position to assist black South African men when it comes to mental health, and in particular, depression.

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Chapter 3

Methodology

This chapter outlines the rationale for the chosen methodology used in order to conduct this research. The qualitative and phenomenological paradigm of this research will be discussed together with the research design, participants and data collection, data analysis, ethical considerations and researcher positionality.

Introduction: Qualitative Research

This research was conducted with the aim of investigating the experiences of depression in black South African young adult men in the workplace, with the objective of the exploring how gender, culture and the workplace influence his experience of depression. In order to gain a deeper understanding of this experience, a qualitative research approach was utilized. Qualitative research implies that there is no universal truth or objective reality, but rather that knowledge is context specific – researchers, participants, ideologies and social structures all form part of the context of the phenomenon under investigation (Lyons & Coyle, 2007). The epistemological stance is empiricist and therefore interpretive phenomenological analysis was used to identify the categories of meaning used by the interviewee's in order to make sense of their events (Willig, 2013). Lastly, there is no mechanical rule in which qualitative research is conceptualised or conducted, as choices and decisions are made throughout the research process and will define and influence the research being conducted (Lyons & Coyle, 2007).

Research Design

The research is situated in qualitative methodology in order to gather information on how young adult black South African men experience depression in the workplace, using an

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interpretive paradigm and making sense of their experiences by listening to them. Qualitative research is concerned with meaning and how people make sense of their worlds and experience events - researchers are therefore concerned with the quality and texture of the experience with the objective being to describe and possibly explain events and experiences (Willig, 2013). Furthermore, IPA allows the participants to express themselves and share their stories without distortion or prosecution (Abayomi, 2017). The study has an aim of understanding lived experiences, therefore the researcher used interpretive phenomenological analysis (IPA).

Consistent with the phenomenological tradition, interpretive phenomenological analysis (IPA) gives researchers the best opportunity to understand the 'lived experiences' of research participants and there is a focus on experiences and consciousness which aims to provide a rich description of lived experiences (Abayomi, 2017; Kafle, 2011; Terre, Durrheim, & Painter, 2006). This point of departure enabled the researcher to gain a deeper understanding of the experiences of depression and how the workplace, culture and gender aspects impacted the men. IPA allows multiple participants with similar experiences to tell their stories in order to find a common meaning of their lived experiences of a concept or phenomenon by focussing on what the participants have in common as they experience the phenomenon (Abayomi, 2017). For this reason, African men of similar age and situations were recruited.

Phenomenology has a focus on the content of consciousness and is concerned with the diversity of human experiences as they present themselves, furthermore, it is not only a description but also an interpretive process whereby the researcher interprets the meaning of the lived experiences (Abayomi, 2017; Willig, 2013).

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The interpretive paradigm by Burrell and Morgan is suitable to interpret the impact of the phenomenon on the lived experiences of the participants (Abayomi, 2017). Therefore, this research is grounded in the philosophy and approaches of interpretive phenomenology, which are usually concerned with questions of considerable importance to the participant and often these issues are transformative and about identity because significant experiences often impact on personal and social identity (Lyons & Coyle, 2007). For the participants, their personal and social identities both had a significant impact on their experiences of depression and each participant experienced this subjectively.

An interpretive epistemology is one of subjectivity, and based on real world phenomena (where the world does not exist independently of our knowledge) (Scotland, 2012). Interpretivists claim that knowledge is culturally derived and historically situated (Scotland, 2012). The researcher had knowledge specific to depression through professional studies and experience which guided the research and was used in assisting to make interpretations about the experiences. Furthermore, an interpretive approach was used as this involves taking people's subjective experiences and extending the power of language and expression to help us in understanding the social world in which we live (Terre et al., 2006). Due to the nature of this research, this was considered the most favourable approach in light of the research aims and understanding the participants' experiences.

Phenomenology does not separate description and interpretation, but rather argues that all descriptions are a form of interpretation which are the products of insights generated between the researcher and the data - the aim of IPA is to explore in detail the experiences and in particular, the meanings of the experiences, in addition to the emphasis that research is a dynamic process with the researcher having an active role (Lyons & Coyle, 2007; Willig, 2013). The researcher has to interpret the individual's mental and emotional state from what he says, which involves adopting different ways of thinking interpretively about the data

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(Lyons & Coyle, 2007). Therefore, it includes a double hermeneutic whereby the participants try and make sense of their worlds and the researcher tries to make sense of the participants understanding (Smith & Eatough, 2007).

In qualitative research, the researcher is often referred to as the 'instrument' or 'tool' in the process which implies that interpretations are filtered through the researcher (who brings their own values and identity to the process) (Salkind, 2010). In this study, the researcher is a white, English speaking young adult South African woman who studies psychology. This means that the researcher is a human being drawing on human resources in order to make sense of the world and on the other hand only has access to the participant's experience through what they report, which is also being seen through the researcher's own experiential lens (Abayomi, 2017). The researcher is expected to critically examine and disclose her position by being self-reflexive (Salkind, 2010). Furthermore, for a qualitative research approach that is 'participant-oriented' and an interpretive research tool, it is important that researchers are always in a state of self-reflecting (Abayomi, 2017). The researcher's stance will be discussed in more detail later in the chapter.

The researcher should be able to enter the participant's world and place himself or herself in their shoes by analysing conversations and interactions between the participant and researcher (De Vos, 2005). This will be discussed further under data analysis.

Participants and Data Collection

IPA works with transcripts obtained from semi-structured interviews, which are transcribed and seen as a verbal expression of the interviewee's mental processes (Willig, 2013). Further, as part of selecting participants for phenomenological research, it was important to select participants' from a similar sample pool in order to better understand the subject (Abayomi, 2017). For these reasons, purposive sampling was used in this research.

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Purposive sampling was used because it illustrates a feature that is of interest to a study, and the sample case was chosen accordingly, offering insight into the particular experiences (Abayomi, 2017; De Vos, 2005). Furthermore, it was anticipated that due to the similarity and size of the sample, the study would be rich and descriptive in the analytical process (Abayomi, 2017).

Qualitative research samples vary according to the requirements and nature of the research question, however, phenomenological research usually contains relatively small sample sizes of between two to 25 participants as an appropriate sample size, with the selection of the participants reflecting and representing the similarity between participants in order to gain a better understanding of the overall perception of the participants (Abayomi, 2017; Guetterman, 2015).

This study aimed to include three to six participants, however, due to the difficulties experienced in recruiting suitable candidates, the final amount was three participants. The participants were black South African males aged 32 – 38 years old and working or living in urban Gauteng. They each had a diagnosis of depression from a healthcare professional within the last two years, to ensure that they were able to effectively reflect on their experiences with relatively fresh memory. In addition, the participants were fluent in English, meaning that they could speak and understand English comfortably enough to converse, although English was not necessarily their first language. They were required to be active in the workplace as opposed to hospitalised or in the critical stages of depression, as this may have hindered their ability to engage and reflect effectively due to the nature of depression.

The participants were recruited by means of an invitation to participate in the form of a flyer placed at businesses and consulting rooms of healthcare professionals (with their verbal permission). Although the researcher placed flyers at several organisations, the responses

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were slow and staggered. The researcher needed more exposure and because she had worked at SADAG, she requested their assistance. She also contacted the South African Federation for Mental Health and several other organisations who were able to reach more potential participants. After ethical approval, the flyer was then advertised on social media platforms with these organisations assistance, which then improved the response rate. After initially screening several candidates, three of the candidates were willing and matched the applicable criteria.

The data collection method for this study was done by conducting semi-structured interviews, which is considered an exemplary method for IPA studies, and has the advantage that the researcher was in a real time position to follow up on interesting, important or unexpected issues during the interviews (Lyons & Coyle, 2007; Pietkiewicz & Smith, 2012). An idiographic approach was utilised, which states that insights are gained by intensive and detailed engagement with individual cases (Willig, 2013).

The interview questions served as a guide to facilitate the natural flow of conversation and included key areas to discuss (Pietkiewicz & Smith, 2012). Literature states that semi-structured interviews may last for approximately an hour, and become quite involved, it was therefore important to ensure that the interview could proceed without interruption as far as possible (Lyons & Coyle, 2007; Smith & Eatough, 2007). The interviews ranged from approximately 45 minutes to 90 minutes. Additionally, it can be said that the most important aspect at the beginning of the interview is that rapport is established with the participants so that they may be comfortable and trust the researcher in order for good data to be obtained (Abayomi, 2017). The participants were comfortable in sharing their experiences, the interviews varied in length and rapport building began from the moment the participants were initially contacted and screened.

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In qualitative research, the questions asked were aimed at encapsulating the essence of what the research aimed to uncover, by posing both central and sub-central questions using an open-ended question formula - therefore probing and open-ended questions were utilised (Abayomi, A, 2017). The interviews were non-directive and provided an opportunity for the participants' to share their experiences of the phenomenon under investigation (Smith & Eatough, 2007; Willig, 2013). In this research, the semi- structured questions included themes consisting of experiences of depression, the meaning of depression to the participants and other relevant aspects. The semi-structured interviews included a set of questions which assisted in guiding the interview but the researcher was not dictated by it, which allowed the researcher to probe interesting areas or concerns (Lyons & Coyle, 2007).

The location and date of the interviews was up to the participants' to ultimately decide – locations were decided based on the participants' comfort, convenience and safety, with alternative locations discussed when needed (Abayomi, 2017). The interviews were conducted at various locations throughout Gauteng, at agreed upon locations after discussing with each participant.

For IPA it was necessary that the interviews were recorded using a voice recording device in order to transcribe the interview for analysis - full consent and approval was given from the participants' (Abayomi, 2017; Lyons & Coyle, 2007). The interviews were recorded on a cell phone and the voice recording transferred securely thereafter to a USB in order for transcription to be conducted.

Data Analysis

Interpretative phenomenological analysis (IPA), a method of analysis congruent with the philosophical assumptions of the study, is an interpretation of a participant's experience from his or her perspective (Terre et al., 2006; Willig, 2013). The aim of the analysis is to

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provide a close textual reading of the participant's account, moving between their description and different levels of interpretation and clearly differentiating between account and interpretation while presenting enough data for the reader to assess the usefulness of the interpretations (Lyons & Coyle, 2007).

IPA provides a set of flexible guidelines which can be adapted by researchers, according to their research aims, which is particularly true with regards to the analysis (Lyons & Coyle, 2007). IPA accepts that it is not possible to gain direct access into a participant's world, and even though the aim is to explore the participant's experience from his or her view, the exploration includes the researchers own world view and the nature of the interaction between the researcher and participant (Willig, 2013).

The researcher used a series of steps that allowed themes to be identified and integrated into meaningful clusters, first within and then across cases (Smith & Eatough, 2007; Willig, 2013). Each individual case was analysed by the researcher according to the following suggested steps (Storey, 2007; Willig, 2013):

Step 1: Reading and re-reading the text: In this step, initial thoughts and observations were recorded in response to the text.

Step 2: Themes were identified and labelled as characterised by each section of text: These themes are conceptual and captured the essential quality of what was being represented by the text.

Step 3: An attempt to introduce structure into the analysis: The themes from step 2 are identified and thought about in relation to one another- some themes formed natural clusters, while others had hierarchical relationships with one another. Clusters of themes were given labels to capture their essence.

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Step 4: The production of a summary table of structured themes, together with quotations to illustrate each theme: The themes should capture the participant's experience of the phenomenon under investigation, therefore some themes were excluded. The summary table includes cluster labels together with subordinate theme labels, brief quotations, and references to where extracts are found in the transcript.

Step 5: Themes are integrated across transcripts to identify shared themes and captured the essence of the participant's experience.

The above steps will now be further elaborated on. The steps were used throughout the analysis and were applied to each participant's transcription (Lyons & Coyle, 2007). Initially, during the transcriptions, the researcher kept a record of initial thoughts, comments and points which had potential significance, as well as identifying common themes or phrases in responses, which could later be checked against interpretations during analysis (Abayomi, 2017; Lyons & Coyle, 2007). The transcriptions were checked again for accuracy and this also allowed the researcher to immerse herself further into the data. It also allowed for clarity and pattern responses in the form of themes, and categorisations were further identified (Abayomi, 2017).

Step 1 and 2: Each interview was transcribed verbatim and analysed using colour coding for common themes (Abayomi, 2017). Each transcript was read several times and the margins were used to make notes about potentially significant information – the researcher felt even more immersed in the data after each reading (Lyons & Coyle, 2007). Comments about the use of language styles, initial attempts of meaning making and convergences as well as contradictions in the participant's talk were noted (Lyons & Coyle, 2007). During this stage, the researcher gradually coded responses into meaningful sentences in order to help the researcher break down the responses into condensed and manageable information, while

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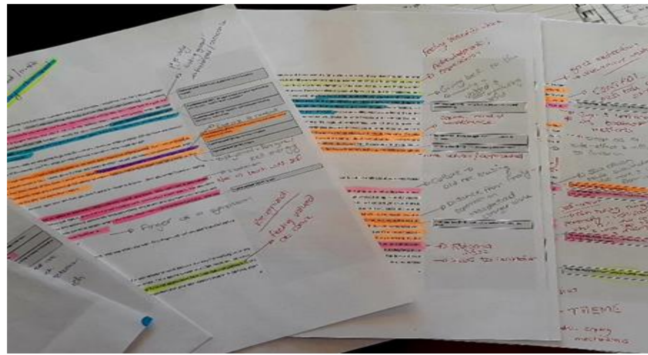
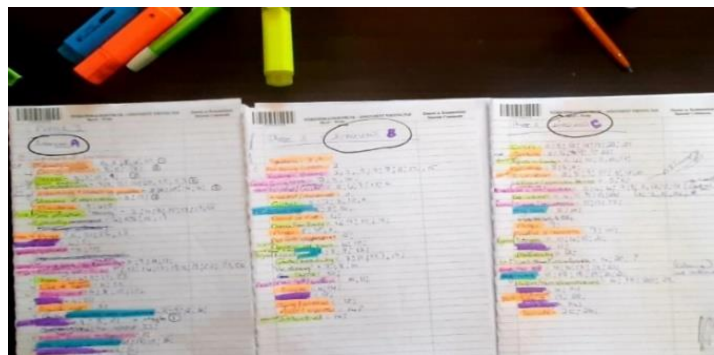
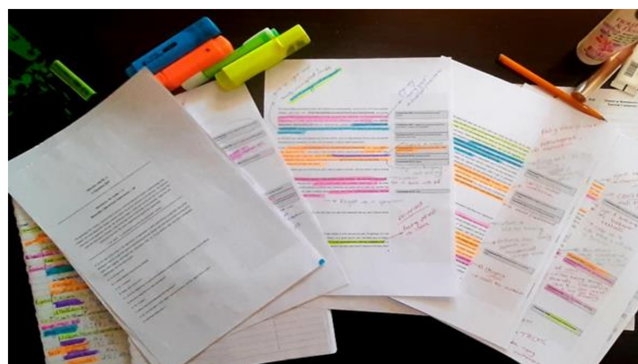
being mentally aware of key words or phrases that were repeated or expressed by participants (Abayomi, 2017).



Step 3: This step brought structure and cluster themes emerged, and were labelled, from the data analysis. This step included another condensation process which involved reducing the first generic statements into fewer words in order to move closer to the core essence of what the participants were expressing (Abayomi, 2017). The clusters of themes were given labels to capture their essence and relationships between the themes emerged.



Step 4: The themes were clustered together, identifying both main and sub-themes. A summary table of the subordinate themes was written on the front pages of each transcript, with the corresponding quotations highlighted and the relevant page number identified.



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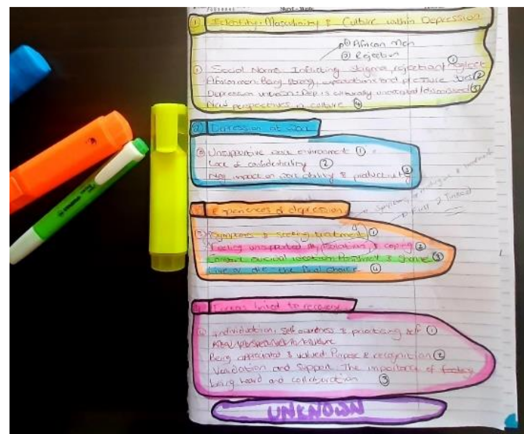
Step 5: Themes were integrated across transcripts to identify shared themes and capture the essence of the participants' experience. These themes were presented together in the document and the quotations and references in the transcript were provided. These themes consisted of significant statements which were grouped together into larger units of information and a textural and structural description – the 'what' and 'how', respectively, of the participants' experience – and the written description, including verbatim examples, were given (Abayomi, 2017). Due to the themes representing the participants' experiences of depression, some themes were excluded (labelled as unknown).



Ethical Considerations

A majority of mental health qualitative research involves interviews and the main ethical issues associated with this form of data collection will be discussed (Harper & Thompson, 2012). Informed consent was obtained from the participants, which entailed informing the research participants about the purpose of the research and any possible risks and benefits from participation in the research (Brinkmann & Kvale, 2017). Participants were ensured that they are under no obligation to participate in the study, and may withdraw at any stage without any negative consequences. All three of the participants agreed and signed the consent forms (see attached "Appendix I"). Furthermore, participants had the right to

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confidentiality, which implies that private data identifying participants were not reported (Brinkmann & Kvale, 2017).

Due to the participants having had a diagnosis of depression, this meant they were a vulnerable population. Emotional harm is difficult to predict in participants despite efforts to avoid harm to participants (De Vos, 2005). Further, there should be minimal to no harm for participants in an IPA study (Abayomi, 2017). Provisions were thus made which allowed for participants to receive free psychological treatment should they require (or request) it at a community psychology clinic in Pretoria (See "Appendix II" attached). Participants who do not wish to travel to Pretoria would be referred to Lifeline or the South African Depression and Anxiety Group (who provide free assistance throughout the country).

The participants were recruited from invitations (in the form of flyers, see "Appendix III") to ensure that participation was voluntary. It is very important to secure and manage the data collected and provide adequate safekeeping of the data (Abayomi, 2017). The data was therefore placed in a secure location throughout the research process and will be securely locked away for storage at the psychology department of the University.

The entire research project was conducted in an ethically correct manner which implied that the researcher was constantly aware of ethical responsibilities (De Vos, 2005). This included but was not limited to protecting the rights, dignity and privacy of the participants', as well as respecting cultural and gender differences and being mindful of value judgements (Abayomi, 2017; De Vos, 2005). Part of this included the researcher's positionality in the research.

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Researcher Positionality

In IPA research, it is important for a researcher to remove any of his/her personal experience (to bracket) from the lived experiences of the participant's during the interviews and collection of data, in order to allow the participants' to fully express themselves (Abayomi, 2017). During each interview, I listened without judgement and with curiosity to ensure that the participants felt comfortable in sharing their story. I believe that they were, as they were quite open and engaged throughout the interviews and they appeared comfortable and were expressive. The researcher is expected to critically examine and disclose her position by being self-reflexive throughout the research process (Abayomi, 2017; Salkind, 2010).

I will begin to describe my positionality with some background information on myself and my interest in this research topic. Having grown up in a large family, different perspectives and experiences were never a foreign concept to me. While growing up, I was always curious about other people and our differences as well as our similarities. Living and growing up in multicultural South Africa meant that I was exposed to other cultures throughout my life.

My interest in this particular research began when I was studying my Bachelor's in Psychology degree through Unisa. My curiosity and views that every human being had a right to be understood, respected and heard fuelled my interest. At the time, I was a full time employee, part-time student and I volunteered at different organisations. I volunteered at the South African Depression and Anxiety Group (SADAG) who advocate for mental health and provide assistance throughout South Africa. It was during this time that through my studies I learnt that in African cultures there was allegedly no such concept as depression. Working in the call centre at SADAG I was further exposed to it as I explained depression and provided telephonic assistance to people who struggled with conflicts between traditional cultural

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norms and more Western norms of mental illness. The initial claims from my textbook, SADAG's claims and my work at SADAG ignited my curiosity in this topic. Additionally, depression may lead to suicide and it was concerning that South Africa has very high suicide rates and I felt that this needed to be investigated. This was evident through news stories and articles which were focussed on suicide and depression in men and various awareness campaigns with regards to it. Through my own research I found that in South Africa depression, particularly in black men, was not an extensively researched topic and I wanted to bridge that gap to better understand others and assist them if possible by adding to the field.

Trustworthiness

There are several definitions and criteria of trustworthiness which exist in qualitative research (Korstjens & Moser, 2018). Further, that some of the well-known criteria are credibility, transferability, dependability, and confirmability as defined by Lincoln and Guba (Korstjens & Moser, 2018). With regards to the trustworthiness of this research, one of the best known criteria, namely credibility, was utilised.

Credibility is concerned with the aspect of truth-value and establishes whether the research findings represent plausible information drawn from the participants' original data (Korstjens & Moser, 2018). Audit and credibility checking were conducted in order to enhance trustworthiness, and this was done via the researcher's supervisor (Harper & Thompson, 2012). Further, the strategies of prolonged engagement and reflexivity were used in the credibility of this research in order to achieve trustworthiness.

Prolonged engagement includes a lasting presence during observation of long interviews and investing sufficient time to become familiar with the setting and context, to test for misinformation, to build trust, and to get to know the data in order to get rich data (Korstjens & Moser, 2018). Several questions were asked regarding the topic, participants

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were encouraged to support their statements with examples, and the interviewer asked follow-up questions (Korstjens & Moser, 2018).

Reflexivity includes acknowledging the importance of being self-aware and reflexive about your own role in the process of collecting, analysing and interpreting the data (Korstjens & Moser, 2018). Furthermore, reflexive notes may include the researcher's subjective responses to the setting and the relationship with the interviewees (Korstjens & Moser, 2018). Reflexivity was noted under researcher positionality and under researcher reflections later in the research.

Conclusion

In summary, a qualitative research study was conducted using interpretive phenomenological analysis in order to gain a deeper understanding of each participant's experience and searching for common meaning and subjectivity across their experiences in order to understand the experiences of depression in young adult black South African men. Interviews were conducted using open-ended questions and an interview guideline and then recorded. The recordings were then carefully transcribed and analysed using IPA techniques. The researcher adhered to ethical standards and was self-reflexive throughout the research process. The findings of the above will be discussed in the following chapter.

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Chapter 4

Findings

The results of an Interpretive Phenomenological Analysis (IPA) on the experiences of depression in the participants will be presented in this section. The findings are considered in light of the research question. Findings are further discussed in the following chapter in an attempt to develop a rich understanding of the experiences of depression in the men interviewed.

Participant Demographics

Name	Age	African Culture	Occupation
Andile	38-years-old	Xhosa	Sports Official for provincial government
Bheka	32-years-old	Ndebele	Process controller
Kabelo	34-years-old	Sepedi	Chemical engineer

The participants comprised of three men who showed an interest in the study after becoming aware of it, either through word of mouth or via social media platforms. After receiving their messages, the researcher made contact with each participant telephonically to conduct an initial screening before setting up face-to-face interviews with each participant. The men had all been professionally diagnosed with clinical depression by either a psychologist or a psychiatrist, and they had all received treatment for their depression and were currently not experiencing a depressive episode. Their ages ranged from 32 years old to 38 years old and they lived in urban areas. All three of the participants had experienced a depressive episode within the last two years - two of them had reoccurring depression. They were all employed within a corporate environment but in different roles and companies, and their work experience ranged from five years to 12 years. The three men were from different

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African cultures but shared similar experiences within these cultures. All of them were able to reflect and speak about their experience comfortably and openly.

Emergent Themes

The main themes found from analysing each transcript were compared across cases for similarity and richness in an attempt to present the shared experiences of the interviewees. Four main theme's emerged from the analysis and each main theme has several sub-themes – which amounted to 13 in total. The themes were similarly experienced by all of the participants. The main themes and subthemes are tabulated below:

Theme 1	***Sub-Themes***
Depressed African Men	• African Men: Expectations to be strong, silent providers. • Depression Unknown: Depression is unknown and culturally unaccepted / dismissed. • New perspectives in culture.
Theme 2	***Sub-Themes***
Experiences of depression	• Symptoms, reaching out and treatment. • Coping with depression. • Constant suicidal ideation. • Deciding to live.
Theme 3	***Sub-Themes***
Depression at work	• Unsupportive work environment. • Lack of empathy, confidentiality and fear. • Negative impact on the ability to work and productivity.
Theme 4	***Sub-Themes***
Factors linked to recovery	• Individuation: Self-awareness, acceptance and prioritising self. • Being appreciated and valued: Purpose and recognition. • Validation and support: The importance of being heard and collaboration.

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Therefore, the main basis of this chapter will be the presentation of these main themes and the subsequent sub-themes. The exploration of themes will be illustrated by using verbatim extracts from the transcribed interviews and will indicate the corresponding page number.

Depressed African Men

This main theme was captured as an umbrella theme for the interplay between the multi-facets of the identity of the participants – particularly with regards to having depression and being an African man. All of the men in the study displayed strong connections with their identity being informed and influenced by constructs of masculinity and from their culture – of which they described had little room for the tolerance, understanding or acceptance of depression or mental health difficulties. However, they did voice that culture was not rigid but open to new concepts and information.

This main theme is comprised of 3 sub-themes, namely: *African Men: Expectations to be strong, silent providers*; *Depression Unknown: Depression is unknown and culturally unaccepted or dismissed* and *New perspectives in culture*.

African Men: Expectations to be strong, silent providers

The construct of masculinity is prominent in some communities and particularly in African cultures where men are expected to provide and have to conduct themselves in ways which compound depression. The participants were expected to be strong and not speak about their difficulties or express their emotions. Further, they struggled to share what they were experiencing because it may be interpreted as being 'weak' and was generally unaccepted and which further exacerbated their experiences of depression. They also felt that they were treated differently to women who were given permission to express themselves, had more

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resources available and had less pressure. Lastly, the men received little or no support from their families when they needed it due to these cultural and societal norms and expectations.

After being asked whether he felt that being a man affected his experience [of depression], Andile disclosed the pressure that he felt and the responsibilities he had while having depression. Further, that he was expected to provide and felt that this was important and that his own needs were secondary to others. He went on to describe that being a black man was difficult as it meant that he could not talk about his experience or share his difficulties [depression and stress] with others as it was not acceptable in his culture and he would be viewed as 'weak':

Andile: *... I was expected to be a dad, I was expected to be a boyfriend at the same time, you know, functioning normally like everybody else. You had responsibilities, I had to care for my parents . . . Uhm, so I went through that process of trying to be strong for everyone . . . . it became a habit where I don't do things for myself. I satisfy and put other people first before me. And with the culture that we have, a man is supposed to provide, you know – so you feel that providing is important. . . . (p. 8).*

Andile: *. . . So being a man was quite difficult in terms of being a black man. And also you can't share with other men, uhm, because we don't, you know we just don't talk about things such as depression – you are seen to be weak. . . . (p. 8).*

Andile further stated that there were little resources available to men who suffered from many things "*There's VERY few institutions for men, men are suffering from a whole lot of things, you know" (p. 22).*

Bheka similarly described what it felt like for him to be a man and have expectations and pressure placed on him without being able to share his experience with anybody. He too had been taught that 'men do not cry' – "*Cause at the end of the day, we've been taught that a man doesn't cry. That's a thing. So, in black men, it's difficult to cough it out, or say whatever you have to say due to such stuff" (p. 2)* and that he was taught not to express himself through

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crying or speak about depression: *"In our culture, we have been taught that a man doesn't cry... and we have been taught that you can't express yourself with such... and there is no-one you will tell about depression" (p.10).* He stated how he was expected to be strong and manage on his own, even when he felt that he wanted or needed to speak to others, he was dismissed and invalidated by being told that he had to 'be strong' – he described this inner turmoil as feeling like being a man was a curse:

Bheka: . . . *Instead, we'll be like 'no, I am strong' - even though you are not strong, even though they can see that there's a problem with you. But the only thing that they will turn out - 'be strong, be strong', even though you don't need that, to hear that you have to be strong. You wanna cough it up, but it's difficult. So, it affected to a point that... being a man sometimes, I used to have that mentality - that maybe it's a curse or something . . . (p. 7).*

Kabelo also shared his experience where he spoke about cultural norms and how he felt pressure to do what was expected of him and when the pressure felt too much, he could not speak about it because it was not culturally accepted and this caused him further pain.

Researcher: *So a lot of expectations on you that you were unable to... live up to?*
Kabelo: *Ya. And I think that, that was just a big problem and. . . . Also on my side, like my upbringing and the cultural things - you just don't... discuss it. And I feel that's the one thing that hurt me the most. . . . (p. 17).*

The men in the interviews further expressed that they felt that they were treated differently to women in that they felt women had the space to be vulnerable and express themselves. In contrast, their experience were that they were expected to be 'men', which meant that they could not portray 'weaknesses' such as crying or struggling. This led to the men keeping to themselves and having the expectation that they were to deal with stress [and depression] alone.

Bheka and Kabelo shared how they felt when they experienced gender discrimination within their culture with regards to expressing emotion and speaking about difficulties. Bheka

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also elaborated that they were expected to manage on their own and not show emotion publicly, therefore not having an outlet or that coping mechanism. Bheka also felt that men had more pressure than women.

Bheka: . . . *Because if you check a majority of us blacks, as I've said before - we've been taught that a man doesn't cry. But at the end of the day, a man do cry. Even though he doesn't cry publicly, but you do cry and what you are facing as a lady, uhm, it turns out that we are facing more than what you face (p. 3).*

Kabelo: . . . *But my little sisters, like she's, she would, well she had a quick outlet - she would cry and she would talk to my mom, like she'll get it out there soon as possible so… anytime she was feeling stressed, she had a way to deal with it. But we not supposed to do that, like, you just not supposed to so you keep it to yourself. Like I'm supposed to get over it so. . . . (p. 12).*

It was further noted that there was a lack of understanding and support from African families, whereby they rejected the diagnoses and this led to further isolation and negatively impacted the men. Culturally, family was important to these men and they wanted the support from their family who were those closest to them. All of the men expressed how they felt rejected and dismissed in their experiences of depression by their family.

Andile spoke about his hospitalisation from depression, whereby his family visited him and he described how he felt rejected and unsupported through his experience – he felt they invalidated his experience and stated that he did not deserve to be there, which he expressed as his attempt to seek help and get better in having a condition he did not choose:

Andile: . . . *One year I had uhm, my partner at the time, they came to see me at the hospital with my mum and they said 'you don't deserve to be here'. A simple question I had, but which I didn't ask, but I had, was 'who deserves to be here?' you know. I'm here because I want to sort myself out, but who deserves to be here? . . . (p. 5-6).*

Bheka also described how he felt rejected by his family when he needed them which felt like punishment to him and further exacerbated his isolation.

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Bheka: . . . So *I had this 'why, why, why' part and my family again, the rejection, it's something that I never took it... uhhm... politely. I felt like it's... it was a punishment . . . . (p. 15).*

Kabelo felt unsupported by his family who did not want to see him in hospital and he felt blamed for having depression and that depression was not a valid diagnosis, but rather a form of rebellion within his family. He felt isolated and judged by his parents and they shamed him, putting further pressure on him and stated how he was a disappointment to them and should 'be better than this'. Furthermore, when he wanted help and to talk [out of hospital], not having their support or being allowed to talk exacerbated his symptoms and led to further mental health difficulties:

Kabelo: . . . *Cause while I was there, cause I went there and then I told my parents that I'm going to be there and ... they didn't want to come and see me. So I was by myself there and when I would talk to my sisters... they made it seem like ... it's your fault... it's like you are just acting up. And... ya, so I was there and there was nobody there... my parents showed up once and they like 'no, you are a serious disappointment, can't believe like this is what's happening to you, you are supposed to be better than this' and ja... so it was quite, quite terrible. . . . (p. 4).*

Kabelo: . . . *And... so I didn't know how to deal with it but then I couldn't talk to my parents, and I couldn't get help from them because... they judge me on that side. So, like I started getting very very anxious and I started getting panic attacks (p. 10).*

Depression Unknown: Depression is unknown and culturally unaccepted / dismissed

In this sub-theme, the importance of culture in the identity of the participants and the concept of depression within African cultures will be identified. The men expressed that depression is generally unknown in African cultures and that is was not well tolerated.

Andile described how important culture was to him, "*I think sometimes culture is, not some, culture is important" (p.19).* He also stated how within his culture, depression was unknown. He expressed that to have stress was normal but that it reached points where it was

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unmanageable and could lead to depression. He is now able to identify possible depression in others and encourages people to speak about it.

Researcher*: . . . is depression something that is spoken about in your culture?*
Andile*: It's not that, it's not, and I think... uhh... people don't even know what it is. You know. You'll find someone 'ay I'm depressed' you know. Uh, people don't - I always say to them... uhh... depression is when there's a lot of stressors that you can't manage, you know, everybody's got stress every day as long as you can manage and you are able to solve those issues going forward. Cause the fact that there are debit orders, already there's a stress, you know, but its normal, it's okay. But when it goes beyond a point where you can't control it and it even controls your mood swings, it becomes depression so if we've got to do something about it. So, there are times where I would see somebody and I'd think ay, this could be depression - obviously you can't diagnose but a lot of times you find, I say 'no, why don't you speak to somebody?', I encourage a lot of people (p. 19).*

Bheka emphasized how important culture was to him and how strongly it impacted his identity. He described how in his culture depression was unknown and they equated it to stress, which would pass. He also commented on how people are rejected for showing signs of depression and that majority of the people reject depression without an understanding of what is happening. He felt that it was important to focus more attention and be more aware in these areas.

Bheka: . . . *Cause the first thing that we... Uhm... we don't know about depression . . . the only thing that we know its stress . . . So, when it comes to our culture, I might say it's... we got that mentality of uhm... there's no such thing as depression, we only have stress. And stress it's something that it comes and goes. . . . (p. 10).*

Bheka: *So far on what I've read... and what I've experienced, I... what, how can I put it? Some of the things that are there, yes, they are but there are... the rejection part, it's also, it's supposed to... especially when it comes to rejection, it's a part where we have to focus on. Because when it comes to these, uhm, especially when you have the signs of depressions and stuff, it comes to a part where you, you are rejected and stuff. And majority, we are blind spotted when it comes to that. Instead of focusing that one, never reject such people, but we reject - not understanding what's happening with them. But it will be easy for us if we, we*

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start to to to be more vigilant when it comes to, uhm such signs and when it comes to a person when they suffer, they start being rejected. So in that way, I think those are the parts where we have to be more vigilant unto (p. 6 - 7).

Kabelo shared a similar experience with his depression, although his culture did not impact as much on his current identity, he noted that it had previously meant a lot to him. He also stated that he did not know what depression was before he was diagnosed. In his culture depression is unknown "*like black people don't know depression and they don't understand it*" *(p. 1).* He felt that speaking about mental health difficulties was very difficult in his culture and that those who had mental health difficulties did not receive help and were abandoned. He stated that culturally depression is dismissed and may be viewed as one's attitude towards things or were ascribed to 'witchcraft' or 'Satan' and that this was still quite prominent. Spiritual rituals or practices were utilised to assist those in distress and when those methods failed that person was rejected from their community. He felt that the cultural beliefs exacerbated his depression and played a big part in isolating him and forcing him to manage his depression alone.

Researcher*: Okay, did your culture influence the way you experienced depression?*
Kabelo: *Ja. It did. Cause... like for us, if you have a mental disorder it's witchcraft. Like honestly, like people like to say it but it REALLY REALLY is, they're just like 'no there's something wrong with you, its witchcraft' or it's Satan or something like that. . . . (p. 22).*

Kabelo: *It's really, really difficult. It really is and like... even, cause I can see with my dad when he has episodes, like the rest of my family just shifts away from him. And... he doesn't get help. They just say 'ag no, like he's starting with his attitude'. And... there's no-one there. So, the culture, the culture is... it's... its quite bad around it actually. Cause there is no space for mental illness. It's just that you... you must get rid of, like you must be in a corner by yourself, you're a crazy person and that's it and if the witch doctors can't help you, then... if church can't help you then you must just be a pariah on the side (p. 22).*

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New perspectives in culture

This sub-theme was identified after an openness to gain knowledge about depression and help others with mental health difficulties was identified in the discussions. Additionally, the men described ways in which they were trying to discuss and normalise their depression and encouraging others to do the same, however, they remained cautious with who they discussed this topic with. The men described their culture as something which can be transformed and was not rigid.

Andile stated that transition needs to happen within his culture as their lives transformed [balance between Western and African cultures] and that men should focus on communication because the lack of communication was causing depression. As previously mentioned, he encouraged speaking about depression with others.

Andile: . . . *So, there's a whole lot of transition that needs to happen with a lot of males, where - not males only - but how we bring culture into what's coming up, our lives are changing. So, we need to find a balance where we, we find a balance and we communicate - and that's not happening and we find a lot of men, especially our age, very depressed because of that . . . (p. 20).*

Further, Bheka stated that the younger generations could introduce concepts and new norms - by educating others about depression and raising awareness. He felt this would be accepted by older generations because they are involving younger generations and showed a willingness to learn and transform.

Bheka: *Uhm... as we don't talk about it full time [depression]... in our culture, it's something that we introduced as youth. . . . but at the end of the day it's there [gay and lesbian people] and this is there, we have to accept it as it is. Same thing when it comes to depression and anxiety, it's something that they grew up without knowing it but when we bring it, it's when they start to be more vigilant and start to want to know about it. . . so, it helps now when we have knowledge as young people and bring it to our elders. And when it comes to our elders,*

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they are involving us a lot in our culture cause they know that today they might be there but tomorrow they might not . . . (p. 11).

Bheka went on to describe that he was already educating men in his culture about mental health through community support groups that he runs: "*Besides me having the group, and bringing such topics unto the group. So, in that way it becomes easy for them to know that there's a thing we call depression, there's a thing we call anxiety. So, the group on its own... the initiative that I started, it helped due to... I'm able to cough it up or to bring whatever that our culture doesn't know about. So, for me to start it, it becomes easy for me to spread the message (p. 10).*

Kabelo did not speak about general cultural changes but rather within his own family. He stated that his family had eventually given up in trying to 'fix him' and had accepted his mental health, which he interpreted as them accepting that there was something happening which they did not understand.:

Kabelo: *I think it's me, cause I wasn't getting better and it's all... cause it's like they trying to... fix you by like... being cruel or being mean or trying to shake you out of it, but then nothing was happening so I think they actually just gave up. I feel like they just felt 'okay maybe there is something that's happening and we don't understand it'. And they just let it be. . . . (p. 5).*

Experiences of depression

This main theme will explore the experiences of depression that the men had with regards to symptoms, getting treatment and how they found ways to cope with their depression. The men shared similar experiences in the way that they experienced symptoms, which manifested as physical symptoms which led them to seeking help. Additionally, their help-seeking behaviours began after severe negative consequences began to form within all aspects of their lives. Further, the participants experienced constant suicidal ideation, some of

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the participants had attempted suicide. Despite this, each of them had made a decision to get treatment and overcome their depression. The four sub-themes found within this theme were: *Symptoms, reaching out and treatment; Coping with depression; Constant suicidal ideation* and *Deciding to live*.

Symptoms, Reaching Out and Treatment

This sub-theme aims to identify what the participants experienced with regards to symptoms and what led to them seeking help, as well as how they experienced treatment. The participants share very similar experiences with regards to this theme. They had initially all noticed physical symptoms which led them to consult with a General Practitioner (GP) and later they had all been referred to and consulted with either counsellors, psychologists or psychiatrists. The participants were all placed on medication at some point during treatment, which they found unhelpful due to the side effects and preferred talk therapy. They had also struggled to reach out initially and felt overwhelmed with stress and struggled to cope, or find ways to cope, on their own.

Andile described how he was experiencing challenges but thought he could manage and it was only when he felt his physical symptoms that he sought help. His symptoms included emesis, headaches, feeling constantly tired (except during exercise) and wanting to sleep more than usual. Further, he was isolating himself, felt irritation and a lot of tension.

Andile*:* [on whether he knew what depression was before his diagnosis] *I didn't know, to be honest I didn't know because… uhm… you always thinking of the challenges everywhere you know, you can manage, you can handle them. I think it's only then when it started, I started feeling it physically – tension, how you get irritated, and you would see the things you are doing, sometimes you wanna sleep longer.. . . So, you isolate yourself and those were the signs. . . . (p. 3).*

Andile*: Uhm, I had tension, I had a lot of tension on my neck and I had a lot of headaches. Uhm I would vomit at times, I would vomit a lot . . . And I would feel tired most of the time, I*

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would feel tired. Only when I am exercising, I would energise but after that… constantly tired and I would just fall asleep wherever I get to rest and sit down and fall asleep. So that, those were the physical signs that I had it (p. 4).

Andile also described how he would lose his temper over small instances *"I would burst or at times just lose it, even if it's a small incident with somebody, I would lose it" (p. 4)* because of built up anger and tension – *"that was just anger, unnecessary anger building up" (p. 4).* Andile stated how his physical symptoms had led him to consult with a GP who then recommended he see a psychologist – *"Because I started with a GP, and the GP recommended I go and see, because she felt my shoulders were a bit tense, I didn't see anything wrong with… I thought I was operating normally you know, until I said okay its fine, let me go and see a psychologist (p. 2).*

Like Andile, Kabelo felt very tired, 'off' and slow, like he could not think, as well as loss of pleasure and irritability – he attributed these to being physically unwell and then sought help from a GP and was later referred to a psychiatrist who diagnosed him. He experienced an overwhelming sense of pressure at work and emphasised the feeling of isolation and loneliness, which preceded him being admitted to psychiatric hospitalisation.

Kabelo*: I thought there was just something off. Like I said, the first things I felt was tiredness. So, I just felt like okay there's something wrong. I'm irritable, I'm just not happy, and being alive actually... something was just off and like I'm not as smart as I used to be and I can't think... everything was slow. I couldn't do the things that I'm supposed to do and I thought okay, there's something physically wrong with me, that's why I went to the doctor (p. 4).*

Kabelo: [When describing what led up to his psychiatric hospitalisation] . . . *, so I was by myself all the time. And then I'm used to being alone but... I was really, really alone and there was no-one really to talk to about it. And, it was the pressure was just getting a bit much at work aswell. Ja (p. 3).*

Bheka experienced similar physical symptoms, however, he was unable to sleep and he also spoke about being forgetful and would try and keep himself busy. Like Andile,

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Bheka also experienced headaches. He spoke about his bitterness and the anger he felt "*the bitterness it was always there... and being short tempered" (p. 6)*, which he had later realised caused a changed in himself and he had become dangerous to himself and others. He started speaking to his brother-in-law, a counsellor, after his sister found his suicidal letter and it was through this talking that he discovered he needed help and was not coping.

Bheka*: Physical symptoms, I might say yes.... Uhm, one - I lose my mind. Uhm, even when we talk about something, I will easily forget. And in some stuff, a headache now and again. Even the body on its own, it used to... now and again I feel like I can't sleep or I can't just do whatever, something, just to keep myself busy even though I'm a... It used to be something, it will be something else that - it was unexpected at the end of the day. . . . (p. 6).*

Bheka*: What made me to decide I needed help... one - I realised that... I had anger and when it comes to anger my girlfriend, my ex-girlfriend, told me that I've changed a lot. And as much as I've changed, I'm dangerous to myself and I'm dangerous to her. And then number two - my sister found my suicidal letter in my car.... and then she read that, then... she called my brother-in-law and then I had to talk to him and when I was talking to him it's when I realised that... I do need help . . . (p. 11).*

With regards to treatment, the participants shared their experiences of not responding well to medication and they had all tried several therapists or counsellors during their treatments. Bheka initially rejected his diagnosis, while Andile and Kabelo had both spent time in a psychiatric hospital as part of their treatment.

Bheka spoke about his experience of when he was initially diagnosed – with anxiety and then depression – he was placed on medication but stopped taking it because he did not like the side effects. He initially rejected the diagnoses and need for help and began to realise he was not coping [suicide letters] and stated it [depression] was negatively impacted several aspects of his life.

Bheka: . . . *I was in denial at first, especially, immediately they told me that I'm having anxiety signs and stuff. And even when they told me that it's, they can't say its anxiety anymore, its*

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depression, it took time. And I was on denial for quite a while and where I realised that I needed help it's when I started to write suicide letters and everything . . . so it affected a lot of my stuff. . . . (p. 4 – 5).

Kabelo was also placed on different medications and had very negative side effects. He felt invalidated and unheard when he wanted to discuss medication and the side effects with his doctors. He later stated that therapy in the psychiatric hospital was not helpful but that the therapy with his current psychiatrist was helpful for him.

Kabelo*: . . . And.... nobody would listen, like... I would read about it, I would be like okay I think I understand what's wrong with me, like I've taken these medications, I've had this reaction but nothing... the one lady now actually told me 'no but you not a doctor so you can't tell me what to do', I'm like 'no, I'm not trying to tell you what to do but... I've been through this and you want us to start the medication from the beginning again'... and some of it was really really bad.*
Researcher*: The medication?*
Kabelo*: Ya (p. 6).*

Kabelo*: Um it was in the hospital with the one lady* [receiving therapy].. *it was also... just... pointless. And then I did last year, or the year before last year, I can't really remember, here, there's a lady here, a psychiatrist. And I've been going to her.*
Researcher*: For therapy?*
Kabelo*: Ya, and she actually helped quite a bit (p.8).*

Andile also did not have positive experiences when he reached out for help. Initially he did not speak to anyone but did try and get help from the wellness unit at work. He was referred for counselling but did not feel heard and that she had failed him, he stopped going. The second time he went for help he was again disappointed because his psychologist fell asleep in the counselling session.

Andile*: . . . I phoned work and I went to this… we've got this wellness unit. I went to a psychologist . . . uhm… she failed in the sense that she didn't, she didn't listen to me. . . That was the first attempt to seek help and I felt she wasn't relevant at the time. And the second time, the psychologist that I saw, which was Dr M* at the time - he fell asleep. . . . I said*

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whatever I wanted to say, but I was pretty much disappointed in the fact that he fell asleep. (p. 6).

Bheka and Kabelo shared what it was like for them to reach out and share their experience with others. Both of them felt uncomfortable and feared the stigma that is associated with mental health difficulties. Bheka was more comfortable sharing with a male psychologist, who he thought could relate to him better due to them being of the same gender and the psychologist sharing his own personal details.

Bheka*: It was... it was uncomfortable. Especially ... to talk about the personality, is not easy and to, to, to express yourself to somebody that you don't even know, it wasn't easy. Cause the first thing comes, its being judged . . . it becomes difficult for me open up. And especially in a different gender. But immediately I find another gender, it was easy for me to open up because he told me what he faced, what pushed him into being a psychologist and any challenges that he's facing as a man. So it's when I started to be more open and to... to, to ... to be more relaxed around him (p. 12).*

Kabelo: [When describing talking to his girlfriend about his diagnosis] *It was scary - it was really scary. Cause the thing it's like... uhh... they just don't know... like... they've heard about it somewhere but they don't, they just lump it as 'you're inane', and that's just it. And get over it (p. 14).*

Kabelo and Bheka both did independent research after being diagnosed to learn more about depression and what they were experiencing as they had never heard of or paid attention to depression prior to the diagnosis. Kabelo describes that he assumed it would be a quick fix and did not expect it to be continuous process.

Kabelo*: Well it's... uhhh... I think it's because I went to the doctor first, I think that's what helped me, is that I... I didn't think it was a mental illness, I thought there was something wrong and I will take meds and I will get better. And the more I was going to the doctors, then the more I had to start reading about what's happening (p. 22).*

Researcher*: So initially you go to the GP, the GP says... something else is…*

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Kabelo: *Well at first I thought okay no it's just something else that's wrong with me, they'll give me medication then it's done. That's what I thought it would be. I didn't know that it's going to be something that's continuous and forever and now I need to find the right meds and get the therapy for it, like I... I just thought okay, he's sending me to the psychiatrist, I'll go to the psychiatrist, I'll get my meds and then I'm done (p. 24 – 25).*

Coping with depression

This sub-theme describes how the men coped with their depression both before being diagnosed and after being diagnosed. Furthermore, it aims to investigate patterns that the men shared before seeking help and what they found helpful during and after treatment. This will assist in understanding how they coped and what may have been most beneficial.

Andile describes the pressure he felt at work and how he felt isolated with his depression, both at work and with people close to him because he did not share what he was going through. He consumed alcohol to cope with what he was going through and manage his feelings. He also tried to cope by exercising frequently - which also served as ways for him to 'punish' himself. He states that his coping mechanisms were not helpful and even though he looked well physically, he was struggling mentally and could not share with anyone, he eventually reached his breaking point.

Andile*: Ya, it did help me to cope* [using alcohol] . . . . *at work I had issues with my boss . . . . uhm so I felt isolated, I felt neglected... not appreciated by my supervisor and every day was just a different day. You come to work you smiling, you leave there you miserable – and you can imagine you spend your 8 hours at work. You know, you sleeping you've got uhh company properties and issues, you know so you always constantly under pressure and there was a time where I felt I just can't take it anymore. Ya (p. 3).*

Andile*: It was building up and the fact that I was a person that would exercise, I would run for…for 6 hours without feeling it, that's how I also - I think I was punishing my body and felt the goals were achieved. I was looking good physically, but mentally you would, you know, you would feel a bit broken . . . people wouldn't understand what I'm going through, and they*

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would say 'no you don't share' and I think in our culture it's, you just don't share anything with anybody (p. 4).

Bheka described a similar experience to Andile with regards to isolation. He could identify the typical symptoms of depression but felt unprepared for the rejection, which enhanced his experience of suffering and he described not feeling understood. Kabelo also described not feeling understood and that people would reject him because he was not visibly sick – he also felt that he needed to speak about his experience to get better but could not and this as one of the worst things he went through and caused him to isolate.

Bheka*: So far on what I've read... and what I've experienced, I... what, how can I put it? Some of the things that are there, yes, they are but there are... the rejection part . . . especially when you have the signs of depressions and stuff, it comes to a part where you, you are rejected and stuff. And majority, we are blind spotted when it comes to that. . . . (p. 6 – 7).*

Kabelo*: They just won't get it. The thing it's... and I think too much. And in my head I'm like okay if somebody's sneezing you kind of know there's something off, but then.... like... there's nothing wrong with me. And I keep saying there's something wrong with me and they not buying, the people who were the closest to me don't seem to get it - then how is a stranger supposed to understand, so... I actually just kept it to myself.*

Researcher*: And how was that for you? Like... not being understood, not being able to describe it?*

Kabelo*: It's one of the worst things you can ever go though. Cause it, the thing it's like you are going through something bad and you're not talking about it but its, you need to talk about it for it to get better. Like, you have to.... you have to tell somebody. And there was no-one I was talking to. Not my bosses, like, no-one. So, I would spend most of the time by myself (p. 11 – 12).*

Kabelo went on to speak about how being unable to speak about his difficulties and stress led to his inability to cope because he isolated himself further and had no coping mechanisms - he tried to manage the pressure alone. He described that although it would not necessarily be easy, it would have beneficial and healing for him to speak about his problems and be able to share his experience with others, "*we don't talk about it - nothing. So, you keep*

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everything inside and you start pushing people away and then you are isolated and then... you gonna break down, you don't, like you can't - it's just too much" (p. 21).

Kabelo further described how he became withdrawn and had several mental health difficulties that he struggled with. He also felt judged by others and in addition to this, he experienced racism at his workplace. His isolation and being unable to speak to anybody about his difficulties caused his mental health to decline further and he developed severe anxiety and then panic attacks.

Kabelo*: Well... it was... the anxiety it started getting... especially at* [company]*, it was really out of control and I couldn't deal with the people. But it's like I would be withdrawn, and then I would be judged for being withdrawn... by like my peers and then I would be anxious to be around them. So... And it's not a very nice environment here. Like, it's not like Joburg, it's still... a bit backwards. So, the white people treat you very very badly, even at work, in the workplace, its actually really bad. And I wasn't used to that. I came from* [area]*, it's not that bad. . . . (p. 10)*

All three of the men described feelings of isolation and rejection before they sought treatment and they all tried to manage their symptoms by isolating themselves and consuming alcohol. Andile stated "*You know, you feel a bit down, completely isolated, and so you hide everything through alcohol" (p.3).*

Kabelo explained that alcohol helped him to sleep and 'forget' his difficulties. The alcohol helped them to supress what they were going through but it was temporary and ultimately not helpful. Bheka went on to describe how alcohol was negatively impacting on several aspects of his life, worsening his situation.

Bheka*: To cope with the symptoms cause… when you... when you not drunk, it was like... you... you not in a normal world. But when you are drunk, you are able to think that 'you know what, this is my world', instead of focusing too much on what I was facing. Alcohol, it was like an answer. But it turns out that it was also not an answer, instead it was affecting my*

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workplace and it was affecting my health and it was affecting even my family... but not knowing . . .   (p 13 – 14).

Kabelo*: Well... the things it's, I was by myself here so I could drink whenever I felt like... and I noticed, okay it's... gets me to sleep. Like I don't have to deal with a lot of the issues. If I can just make it back from work, then I know that my bottle is there and then.... I'm sorted. So it just... ah... it helped me forget the stuff (p. 10).*

With regards to treatment, the men were not in favour of medication and did not like the side effects and/or effects of the drugs. They preferred to speak to people, and particularly therapy. Andile described how he was not comfortable speaking to people close to him because he felt they did not understand and his therapist listens to him and they have a relationship whereby they share things and this is helpful for him.

Andile did not want medication because of the side effects, "*I said to them I don't want anti-depressants. . . . I want to have that ... I would rather deal with that naturally – there are processes like gym, socialising, speaking to people – I would rather take that route than take the severe medication route" (p. 7).* He went on to share that his psychologist helped him through several difficult situations and was very helpful. He seemed to appreciate his relationship with [his psychologist] and found therapy helpful, "*doesn't do much - she listens. You know. . . . and she would share her stories as well. So it's become that kind of a... sessions that I'm attending. And I think it's working for me" (p. 10).*

Bheka found it easier to share with other men rather than women because he felt that they experienced similar pressures. He did not want to be told to 'be strong' and wanted to talk about his feelings and what he was going through because this was helpful and healing for him.

Bheka*: Yes, instead of you being told 'no, be strong, you'll be fine' – those are not what you want. I just want you to be there for me and for me to talk to you and to tell you how I feel. In*

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that way it becomes easy, cause some of the things are things I have to speak them out, not just to hear you telling me that I have to be strong (p. 8).

Like the others, Kabelo also found it healing to speak about his problems. He found therapy to be very helpful, and exercise and routine had also helped him to cope. Furthermore, he no longer keeps things to himself and will raise issues and concerns with his family so they do not become problematic and this has helped him to manage his depression and cope better.

Kabelo: *Ya, so... it's when I started gyming again and just trying to live life but every time I have, like, a downward spiral I just let it be... then I try to get back into the routines, get rid of the riffraff... and... start again. . . . (p. 17).*

Kabelo*:* [speaking about how his current relationship is with his family] *Well... ahhg... its better, but they don't like me much now because I'm not... all soft and cuddly, if something's wrong, I'll say somethings wrong and I'm unhappy now. So that it's finished, cause I know that I'm not gonna be able to deal with it. So, if I can see that there's somethings that's off in the house, usually I'm the one who's gonna say 'there's something wrong, we should talk about it'. But you not supposed to talk about stuff so they don't like me much. But... [laughing] (p. 23).*

Constant Suicidal Ideation

This sub-theme explores how the men experienced constant suicidal ideation. It was evident within this theme that suicide ideation was quite prominent in their experiences of depression and they struggled with these thoughts on a constant basis. The men had also planned ways in which to commit suicide.

Andile reflected on the continuous thoughts surrounding suicide, "*…almost every day, almost every day. At the time it was almost every day, you know. Every time I was driving . . .*" *(p. 21).* He did not want his death to look like a suicide because people would not expect it and to protect his daughter so he had constant thoughts of how he might be able to make his death appear to be an accident.

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Andile*: I did, I did. Uhm, I did... I think... uhhhhh.... the reason I never committed suicide because I felt my character and my personality as well, I'm not somebody who's gonna take pills and medication, people say 'ey wow I didn't expect this from Andile'. I've always thought about driving at 200km per hour, there's a truck coming, drive in front of it and that's it. I've ALWAYS thought about it. . . . And hoping that something comes up and I'd have an accident and I'll die and in that way people see there's an accident only to find its, it was a suicide. Uhhm, I didn't see myself.... shooting myself and everybody says 'ah but we didn't see this and that' because like, I also felt that I will defend my daughter. So, if it was an accident, ey daddy died in a car accident, nobody would know that actually it was suicide. That was the kind of suicide I was... I was... thinking about, as compared to maybe medication and things (p. 21).*

Bheka also had constant thoughts about suicide and found himself investigating which poisons would be most effective because he worked in a laboratory. Like Andile, Bheka's ideation involved methods at his disposal at or during work. He further felt that any stress or confrontation triggered him into thinking it would be better for him to die – he opined, at that time, that the deceased had a better life than him.

Bheka*: More often.... more often. Especially.... when I'm alone, I'll think about it to a point that you will even go to google to check which poison it's easier. As I was working in a lab, for me to think about it, it was... something else. Especially when I'm at work cause at the lab, I work with different chemicals. I know which chemicals is dangerous, I know which one is not dangerous. . . . Even if maybe somebody angered me, the first thing that will come, instead of me being violent, instead of maybe me laying hands on them and stuff, the first thing will be 'it's better for me not to live' - instead I want to die - I think it's better if I'm dead instead of me facing such things. Or even if I'm facing financial stuff, the first thing that will come, instead of me struggling and stuff... 'let me die'. Cause it's like those who are dead, they are living a better life than us. Instead of me being struggling while I see there's a better way where I can just vanish to, in front of everybody (p. 14).*

Kabelo shared the experience of constant suicidal ideation and had a plan of how to execute it – he would stop taking his medication and collect it in preparation for an overdose. He had never attempted suicide, although he also stated that he experienced overwhelming pressure and that suicide and death appeared to be an easier option to escape it.

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Researcher*: Okay. Did you experience suicide, suicidal ideation or try and commit suicide?*
Kabelo*: Well ja, like there were quite a few. But then I didn't really try to commit suicide, but I always thought about it, like I would stop the meds and... I'd prepare for it. But then I've never done... done anything.*
Researcher*: So how often did you think about suicide?*
Kabelo*: It was constant. It really was. Like, the time that I was at Sasol that was the worst, worst time. And at that time I thought it's much easier just to check out.*
Researcher*: Okay.*
Kabelo*: Ja.*
Researcher*: Did you have a plan?*
Kabelo*: Yip. Like I say, I stocked the meds, like I got pills and I'd stock them and I knew what I was gonna do (p. 25).*

Deciding to live

This sub-theme explores the reasons behind why the men did not complete suicide. They shared similar experiences in that they felt that the risk of death by suicide had become quite prominent and they had each made the decision to live and get better, for various reasons.

Andile described how he felt he ultimately had to make a decision, "*I think I had to make a decision because either I was going to die... I would've perhaps committed suicide" (p. 20)* and part of what motivated him to live was his daughter and that he wanted to care for her. He also reflected that he had never gotten the opportunity to commit suicide. He, however, had been involved in several accidents and incidents which had the potential to kill him but he survived – he interpreted his injuries as punishment for wanting to die and therefore did not use analgesics so he could 'take his punishment'.

Andile*: Partly my daughter and I think I just didn't, I think I just didn't get a chance. Honestly speaking I think, I just, it just never got to a point where I got that chance to... to do it. . . . I think it just never happened that I, I got the chance. But I would've done it... I would've done it. And I think I also saw it with my car accidents. When I had these car accidents, I... I didn't feel pain... you know. It was pain, but to me it was normal, and you find somebody, everybody*

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saying 'you know this guy can take pain, this guy' - I don't use painkillers anymore, to from that time I never use - cause somehow it felt like punishment if I was taking it and I needed to take it and... III... I don't feel pain when these things are happening, I don't feel pain. Like I had a... I had a motorcycle accident... I was okay, at the hospital I was critical but... I felt why, why didn't I, you know why didn't I die? I should've died... uh... so I think I converted whatever there to... if... the... this pain, I used this pain as if it was somehow a punishment of what I wanted to do there... (p. 21).

Bheka had attempted suicide twice to try and escape his stressors and the pressure of being investigated, he struggled to understand why he was being accused of a crime he did not commit and this also negatively impacted on all aspects of his life – both at work and personally. He struggled to cope with the accusations and rejections from the people in his life, particularly from his family and sister, who he was close to, "*I had a lot in my mind so I thought 'you know what, for me not to talk to my sister like this', while we are too close and we would go for movies together, camping together and now this, so I'd rather... shift in front of her... I would rather die and so that she can live freely cause it's like I'm disturbing her even in her house, same house, living together, we just passing each other - no 'hi', no nothing. On that one, that one on its own, it was... hurting me" (p. 15).*

Furthermore, because he experienced a lot of pressure and rejection, he wanted to escape - and for him suicide was an option in which to achieve this.

Bheka*: I had a lot on my plate. Cause... one - the rape issue... the question I had, it was 'why, what happened? What wrong did I do to her?' and what led her to think of... rape cause I never forced myself to her. . . . So I had this 'why, why, why' part and my family again, the rejection, it's something that I never took it... uhhm... politely. I felt like it's... it was a punishment.[…] Now and again I have to call lawyers, I have to do a lot of stuff, for something that I never did. So… those things, they used to push me to a point that... I needed to see myself out in front of them. Not seeing them anymore, not to hear them anymore (p. 14 – 15).*

Kabelo was able to seek help before he attempted suicide by admitting himself into a psychiatric hospital, "*Like on the suicide stuff, I didn't really, like it was a constant thought...*

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but… I never really did anything. There was nothing really bad about it. And I think I checked myself in before it got to that point" (p. 25). He could not recall what stopped him from attempting suicide, although he did speak about concern for his parents and how they would explain and manage his suicide.

Kabelo*: Ja. Well I thought okay if I die then who's... gonna know I'm dead. And then, once they do find out I'm dead and... my parents are gonna now have to deal with this and they're gonna have to come all the way here, take my body, and then they're gonna have to explain to other people what happened... so let me rather not (p. 26).*

Depression at work

This main theme will explore the experiences of depression that the participants' had with regards to their work environments and how it impacted on their work. The men again shared similar experiences and across the interviews it was identified that there was a lack of support and a negative impact on their ability to work or be productive in the work environment. The main themes that emerged from this theme were *Unsupportive work environment*; *Lack of empathy, confidentiality and fear* and *Negative impact on the ability to work and productivity*.

Unsupportive work environment

This sub-theme describes how the participants felt with regards to the high expectations and the pressure that they experienced, as well as the lack of support they felt within their work environments. None of the participants felt supported at work nor felt that it was a space where they could be vulnerable and open. Furthermore, although there were services in place to assist the men, they felt these were either ineffective or part of company policy and ultimately lacked substance.

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Andile described how he enjoyed his work but that the pressure and expectations placed on him were very demanding and he did not notice the way this affected him, "*. . . So, you get those dynamics where your work affects you but you don't even see that it affects you in a certain way . . ." (p. 9).* He did not feel supported at work with regards to his depression, except for a counselling service – a wellness unit - the company provided to employees. He used this unit after exhausting his medical aid funds.

Andile: [When asked whether he felt supported at work] *I didn't, I didn't . . . because whenever I push, they would assist. There was a time, I remember with my medical aid - GEMS - you only get five sessions to see a psychologist and I recommend and I went to them and I said guys, I've exhausted my five sessions is there a way - because I started paying cash, they were R700, R800 per session - so they said no, we can assist, you can go through our processes with.. we start you know, so what I do is I pay with my own medical aid and at the time, pay with my own medical aid when it exhausts for the year then they, then they support with that as well.*

Researcher*: The Wellness unit?*

Andile*: The Wellness unit yes (p. 15 – 16).*

The wellness unit consisted of telephonic counselling, which Andile did not find helpful as he felt they did not effectively address his concerns, "*even the counsellors, [giggles] telephonically, they refer me to with the bible and this - that's motivation which I understand, but you need to be realistic as well, you know" (p. 17).*

Bheka never spoke about his diagnosis as he did not feel comfortable and when he did try and speak to his manager, she was not supportive but condemned him instead for not speaking out sooner. He only reached out when he was in trouble and did not feel supported. He was further disappointed that they did not follow up with him afterwards, "*So, I can't say I was supported to that cause even they've never made a follow up or something" (p. 9)*.

Bheka*: I never spoke about it and even after they told me everything, I tried to speak with my area leader but by then, due to the results and everything, she never listened to that. Because*

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she said 'no, you were supposed to say it from the beginning, instead of saying it now, why you are in trouble'.
Researcher*: Okay. Did you feel comfortable speaking to your work colleagues about it?*
Bheka*: Nope (p. 8).*

Kabelo shared a similar experience with regards to not feeling comfortable speaking about his problems with colleagues or managers, "*No. Even now, like, some of my colleagues, I just... it's the one white guy – 'E' - I talk to him quite freely and one of the guys, one of the black guys, but he doesn't get it and we are in the same office so if I disappear, he asks" (p. 19)* and *"... at work it's hard for us to talk about it. Especially for black people, that's the one thing I noticed is that...." (p. 5).*

Like Andile, Kabelo's workplace also had support available to employees but he did not feel they were effective but rather in place as company policies and guidelines *"They do have them in place but... uhh... it's to tick a box to be honest" (p. 20).*

Further, he felt that the company expected him to be at work regardless of his experiences and to 'fix himself' and come back when he was better, "*But then... in the corporate world it's like sometimes they want - you need to show up. And you say 'I'm not okay' and it's like okay, suck it up and then take the weekend off and that's it" (p. 21).*

When he did share with his boss, he said that they tried to have him medically boarded to 'get rid of him'. He did not feel supported at work and felt that in his corporate environment there was little tolerance for not being well.

Kabelo*: Ya, because if you tell them 'okay, I have this problem', it's 'okay no fix yourself and then come back' - that's the type of attitude. So... and when I actually told my boss in [company] about what is happening then HR showed up and then they had this… uhm.... not the disciplinary... it's like this programme that they put you on for, to get um, to get you to the point of... what's this word.... wheeenn... you can't work anymore because of a disease that you have, there's a certain word that they use...*

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Kabelo*: Ya so it's like they medical boarding. So, it's like they trying to get you onto the boarding cycle so that they have all their paperwork and after a year you are boarded and like they done with you (p. 20).*

Lack of empathy, confidentiality and fear

This sub-theme describes how the participants felt at work with regards to confidentiality and sharing in the workplace, particularly with regards to sharing their difficulties and problems with their managers and colleagues. It was identified in this theme that the men did not feel that their conversations or personal difficulties were confidential and this prevented them from sharing or seeking help. They also experienced stigma in the workplace and a lack of empathy from managers and colleagues.

Andile felt uncomfortable sharing his experiences at work because he felt that colleagues would insensitively discuss the mental health of other colleagues by making jokes about them. This caused him further pain and because mental health was not taken seriously at work, it caused him to pull away.

Andile: . . . *People are just throwing it out there and I became very sensitive when it comes to issues of depression and how people treat other people because you would see people with bipolar and pick up you know, that these are symptoms… but how they're being treated, it's made a joke – 'guys he's bipolar'. So I , I , you know you start feeling pain because you know that you are also going through something. But it's only once you've learnt and become comfortable with it that you are able to help others as well. So when I felt people were mocking other people, I pulled back. Hence, I wasn't sharing that much (p. 6).*

Apart from wellness colleagues, he felt like his colleagues would not understand and that they might use his struggles against him and a bad experience with this caused him to withdraw and refrain from sharing personal events at work, "*I felt they didn't understand. Cause like there was a time when I spoke, I only spoke to my wellness colleagues and it was, they were very helpful. But I felt they didn't understand and they'd use it against me. . . . Uh*

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so from that time I felt that I'll keep whatever that's mine to myself and not share with anybody, you know. . . . (p. 16).

Bheka also felt a lack of understanding and confidentiality within his work environment and did not feel comfortable sharing anything personal.

Bheka: [When asked whether he was comfortable speaking to his managers] *Nope. I wasn't... due to... the environment, workplace, usually when you speak something - I might tell you whatever but at the end of the day I will hear it from somebody else. So, it becomes difficult to bring your personal stuff at work. Instead you rather stay with your personal stuff instead of sharing them at work (p. 9).*

Although there were resources available to help, Bheka did not utilise them for fear of his difficulties not being kept confidential and of him being 'exposed' to his colleagues, "[Company] *is a big company. So, for me to, to go through it, I have to go via my manager and for me to via my manager it's me exposing myself to colleagues with what's happening to me. So instead I never shared it, not saying whatever. Unless if we had straight line to the guys, it was going to be easy . . ." (p. 9).*

He further described that he would feel better if he was diagnosed directly to ensure confidentiality instead of it going through a manager, *"it will be best if they bring the resources at work and make it available instead if a person feels, got maybe, the results of being diagnosed or something... instead of going via the managers and supervisors, I think it will be best if I go straight on my own" (p. 9).*

Kabelo did not feel that he could reach out for help for fear of the repercussions that would take place - in his case it was to be medically boarded. He also spoke about colleagues who struggled with mental health difficulties in his company and how they were managed.

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He went on to describe how the company was trying to 'get rid of' a colleague who had bipolar, thus he felt mental illness was not tolerated or accepted in his workplace.

Kabelo*: Ya, so it's not that they put it there so that life can be easier, so okay he needs to go and now we must follow the procedure for him to go.*
Researcher*: Okay. So that's what made you uncomfortable to approach and to look for help?*
Kabelo*: Ja, well you can't really. Cause you can't - and I've heard of other guys. I've heard of other guys that...*
Researcher*: Who were boarded?*
Kabelo*: Well, they wanted to board them cause of mental illnesses. Even now, there's one guy that they trying to board at my new workplace and he's bipolar. But it's like he doesn't understand the process of what's happening so you can actually see they are trying to get rid of him, so they not even going through the boarding procedure, trying to say he can't do the work so he must go. Ya, so they putting him through the disciplinary route (p. 20 – 21).*

Negative impact on the ability to work and productivity

This sub-theme explored the impact that depression had on the participants' ability to work and productivity, as well as time taken off from work due to depression. It further explored how the men felt at work and how they described their performance at work. All three of the participants had taken time off from work because of their depression. Further, they had all experienced negative consequences with regards to their ability to engage in work related tasks and had all expressed a lack of productivity at work.

Andile described how depression impacted him in that he felt he had lost his passion for other hobbies and activities due to his boss wanting him to focus only on his work and him allowing it because he suffered from depression, "*…and doing work, coaching in the after hours, helping kids, was my passion and she, she [boss] killed it completely. But I think I allowed it because of my depression - 'no, no its fine I'll leave everything' you know, you say that and you want to focus on this thing called work" (p. 11).*

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He also felt that he did not perform at work, and did only the bare minimum. He described being physically present at work but ‘absent’ – he missed several events and did not care about his performance or rewards, nor did he feel his company appreciated the work he did despite him being proud of his work [when not in a depressive episode]. He felt his work environment placed more emphasis on being physically present than on productivity.

Researcher*: How did it impact on your work?*
Andile*: Uhm, I didn't perform, I didn't perform. And I think I performed to the bare minimum, which... in that environment was still good enough. Because... they didn't know what high quality work is, because they didn't appreciate it, so it was okay, I didn't care about performance, bonuses, I didn't care about certain things whether I missed them or not. But that meant I didn't perform, according to my standards. Uhm, but to them, ya it was, 'ja no he was there'... you know, sometimes... numbers are more important than the impact, which is what I find difficult in my work environment. Being physically there, it's more you can end up in a meeting, sit, not saying anything... ya, it was ya you know, but the impact, did he contribute? So, I... I mean, I think I became very upset I couldn't, I could be at work physically but I would be absent. . . . (p. 12 – 13).*

Andile also had to take time off from work due to his depression and stated that it was ‘a lot’. He went on to describe that at times he took months off, which may amount to over 12 months in total. He stated that there were times he felt he could not work and would frequently be sick and get sick notes because of his depression.

Researcher*: Did you ever take time off because of your depression?*
Andile*: I did. A lot. I did. Uhhm, I did. Uh, sometimes I would be away for six months, you know, just show face, leave, and be absent, you know. Uhm I had... uhhm... incapacity leave for almost six months. First time, then I had a second one came. I think, probably I've taken in, since I've taken over, 12 months. You know I'd constantly be sick, sick notes. There are times where you just don't want to go to work, you feel I can't, I can't, you know - I can't do it, ja (p. 15 – 16)*

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Bheka had a similar experience in that he performed poorly and was not able to focus - causing him to lose his full time position and be placed on contract. He went on to state that he had made a lot of mistakes and his contract was eventually terminated.

Bheka: . . . *And when it comes to work, it affected me to a point that I wasn't able to focus, to a point where some of my results were not good and it put me to a point where I have to go for quarterly contract, no longer full time. Three months in, one month out... so it affected a lot of my stuff . . . (p. 4).*

Bheka*: No, I'm no longer at [company] anymore due to they terminated the contract due to my results when they checked from back then, they find that its... a... I did a lot of mistakes and which they can't tolerate anymore, so they had to terminate the contract. So now I am focusing on my initiative (p. 16).*

Kabelo had a similar experience and spoke about almost losing his job because of his depressive episode. He checked himself into a psychiatric hospital during one of his episodes when he could not manage anymore and went AWOL from work, "*Like I had a really bad one. And... I almost got fired, cause I just, I checked into the... hospital, but... and it wasn't mmm... it wasn't Vista, it was somewhere in Vereeniging. Cause I got a psychiatrist this side. And I just went in but then... I didn't tell my boss, with nothing so it's like I was AWOL. But it's like, it was just, I had to go. It was just too much" (p. 5).*

Kabelo also spoke about how he could not do the work he was meant to and locked himself in his office to cope, *"Ya. No, I just couldn't do the work I was supposed to" (p. 10)* and *"I had to lock my office door, most of the time and just let it go through" (p. 10).*

His depression impacted on his ability to work and he ended up quitting his job before he lost it, "*Ya. Like at [*company*] it was really really bad. Like I almost lost my job, I actually quit [*company*] because I knew... I'm going to lose my job. So I thought okay, let me just get out of this environment and then go... to varsity" (p. 17).*

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Kabelo went on to describe that for a long time he was not working and would lock himself in his office until it was time to go home for the day and did not feel 'alive' during this time, *"I was just, it wasn't working... I wasn't doing anything, I was waking up in the morning, getting to work, locking the office, sitting there until the like, half past four and then waiting for people to leave and then I go so... I was just not alive" (p. 18).*

He also took time off from work due to his depression for the psychiatric hospital stays and recovery - amounting to approximately two months.

Kabelo*: Uhm, it was two weeks in 2013 and then one and a half months in 2016.*
Researcher*: For the hospital stays?*
Kabelo*: Ya. But that hospital stay was also two weeks but then I took another month after that (p. 18).*

Factors linked to recovery

This main theme aims to explore what factors were linked to the participants' recovery and what they found most helpful in order to get an idea of how to assist others in similar circumstances. The participants all went through many difficulties and struggles to reach their recovery and they are all coping and feeling significantly better than before – both personally and within their work environments. The most prominent themes that emerged from this theme which were related to their recoveries were *Individuation: Self-awareness, acceptance and prioritising self; Being appreciated and valued: Purpose and recognition* and *Validation and support: The importance of being heard and collaboration.*

Individuation: Self-awareness, acceptance and prioritising self

This sub-theme explores how Andile and Kabelo came to accept their depression and journey through treatment. They also became more aware of themselves and their needs as individuals and this understanding helped significantly in their recovery and overall well-being. The men had begun to notice a significantly positive change in their depression when

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they had accepted their situations and diagnosis. Furthermore, as the men prioritised their needs, they found that they were able to manage stressors and overall well-being better.

Andile spoke about how he had reached a point where he prioritised himself. For him to reach this point he had accepted his 'reality' and made a decision to not let his adverse experiences 'destroy' him. His perspective changed when he started to accept certain things in his life and he looked for meaning in situations, "*...It's acceptance of what the reality is... uhm, its either you allow it to destroy you or you allow it to build you. Uhm, even the things that have happened in my life, when I share with other people, 'What?!" - you know. But I felt that it's either they had to come with a lesson and I had to find that lesson in it, or I had to understand and I find meaning in anything that happens in my life, you know" (p. 14 – 15).*

He went on to state that he prefers not to rely on people for things because then he may be indebted and therefore preferred to try and rely on himself – this included work situations. Furthermore, he stated that he believed he was different and rejected the societal boxes he felt he had been placed in and he also began believing that he had purpose and value which helped him to gain a different perspective of himself.

Andile*:* [when asked how he changed] *Uhm... I think, you know you've got to start, I believe that I'm different. I started believing that I'm different and I think the society that we live in wants to put you in a box, they want to limit on how you are doing things and how you are, but only when you start believing I'm different and and believing it, and not wanting to fall on the same the same package as everybody else. . . . So once you say you still have values, you still have a lot to contribute... and that's how you're going to change and that's personally how I changed - I said that I still have a lot to give. You know (p. 24).*

Andile went on to elaborate how he went through a process where he stopped believing in a lot of things in his life and started to question his religious and cultural beliefs because they were not providing relief or answers. Furthermore, he had to recreate himself and start believing in certain aspects again after making that decision for himself out of free will and

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understanding that the answers he wanted were within himself. ". . . *Uhm but, I stopped believing anything, honestly speaking, I stopped believing in God, I stopped believing in in traditional stuff, I said 'look, let me be with this and whatever comes my direction and... and I start believing in it all over again', so some things I had to start believing in them all over again. . . . " (p. 17).*

When Andile spoke about his healing process he mentioned that tangible things – for example, visiting his parent's grave after their passing – helped him to manage but at a certain point he realised he did not want to be dependent on this. He started finding other methods to cope which were part of his upbringing – for example, religion and the bible. This further endorsed his stance to not be dependent on anything – it was important for him to be independent and to be able to rely on himself and find what worked for him and his needs.

Andile: . . . *- and so THHAT became my healing process, you know, so I attached my healing to certain things there were tangible. You know I'd go there to the graveyard and I'd leave. And there was a time and I'd said okay, I've got to somehow cut on it because I can't be dependent on this, you know, something else has gotto come. I started reading a bit of the bible there and there, praying and said 'okay God, this is how I grew up, this is the route I know, so those were things that started - and then a lot of things, positive things, started coming in my direction, you know (p. 17 – 18).*

Kabelo spoke about how when he decided to accept his depression he started to feel better and it became less of an 'issue', "*…after seeing the lady here, like the psychologist, it's like I stopped caring about it that much. Like, uhm, its who I am and when I started accepting that, it got a bit better actually, so I don't really mind talking about it, it's no longer really an issue. But it helps, because I know I'm crazy..." (p. 15).*

Kabelo prioritised his needs, both at work and personally, and took time to focus on his mental health and well-being when he needed to. He describes that this helped him a lot

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and he was also less inclined to take things personally, for example other people not understanding his depression, and therefore did not get upset.

Kabelo*: Well its better, ya, its much much better. And like I don't... things aren't as personal anymore. It's like I understand, like my mom, I don't think she'll ever get it. She never gets it. But, I don't have that issue anymore - it doesn't make me upset. It's, I understand she grew up in a different time, with different people... it's just not a thing for them (p. 15).*

Kabelo had labelled himself as 'crazy' and stated that he enjoyed this label because he felt like he was never a 'normal' person. Since he had accepted his difference and the things he likes, he noticed that things began to change for him and he was able to move forward. For him, the greatest concern was that people did not speak about their problems and he felt that this was unhelpful. He further stated that he is dealing with 'sicknesses' like many others and his acceptance made things better for him. Furthermore, he felt less isolated and more accepted within himself - "*But it helped, like accepting that.... I'm not like everyone else. Maybe a bit more like everyone else" (p. 17)*.

Kabelo*:* [When comment was made on the strong way – "crazy" – he described himself] *Ya... but I actually like it, I prefer it that way.*
Researcher*: Tell me more about that?*
Kabelo*: [laughing] Cause, that's when I'm at my best - like I don't, I've never been a normal type of person - I really have never been, I like weird things... black people think I'm weird... and, I don't know, like, I'm okay with that. And the things its, the thing is as soon as I became okay with that then things started to change. Cause then I realised, you know what, people have issues... some people have like real issues and ... the biggest problem is that they don't talk about it. And… I'm not going to do that anymore, cause I've done it - it doesn't work... so... if I'm crazy, I'm crazy - I must just own it and move forward. And it's kind of nice... [laughs] (p. 15 – 16).*

Kabelo also stated that he prioritised himself and accepted that others may not understand his condition, where previously he would try to be 'perfect' which caused breakdowns.

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Kabelo*: . . . so I just focus on... me, most of the time. So, it's like I know that I'm going through something and... if you don't get it, you don't get it but then... I'd spend all of my time thinking about that person and like trying to be the perfect human for them and I'm suffering - and at the end of the day then I'm the one who's going to have the breakdowns. . . . (p. 15 – 16).*

Kabelo learnt the value of prioritising his needs which meant he could remove himself from stressful situations, "*. . . Ja, so as soon as I started focussing on me then things did get better. Cause a lot of these triggers are being removed" (p. 23).*

He went on to describe that he became 'this guy' after seeing a therapist and reflected on and questioned his beliefs, as well as reading books and learning more, and becoming more authentic and true to himself which helped him to manage everything better.

Kabelo*: Like it... uhhhh... I think it was the time that I really came... became... this guy, it was the end of 2017 when I started seeing the lady, the therapist. Then I started to question some of the things and... why am I doing some of the things, why do I care about some of the things, and then I started reading books. And that actually, that just changed everything. Like I knew the type of person I was but then I almost thought it's not okay to be that person (p. 23).*

Being appreciated and valued: Purpose and recognition

This sub-theme explores how feeling appreciated and valued assisted Andile and Bheka in overcoming their depression and in finding purpose. For them, these were important factors in contributing to their sense of self-worth and value as it added meaning to their lives. They felt that by being needed and by contributing to others' well-being positively, it had a reciprocal impact on their own well-being. Further, it had a positive impact on their well-being when they received feedback that their work and effort was appreciated and recognised.

Andile spoke about how important his job was to him and how much he valued appreciation within his role but felt he did not receive that and this exacerbated his depression. When he spoke of his current employment, he states that his director appreciates his work and gives him several tasks to do and he does them with 'perfection'.

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Andile*: Most of it was related to work ja. Most of it was related to work because the way I'm working I'm in the department that I always wanted to be in, you know, I'm a sports person and I felt there was no other... environment I could go to besides being here. And if I'm not appreciated here, I felt lost, completely lost. . . . I'm not the person who wants somebody to say 'hey you are appr..' but just acknowledgment of, 'thank you for the report, thank you this' because with them there was never peace. There was always constant fights… and I just felt neglected, not appreciated. . . . (p. 4 – 5).*

Andile: . . . *So the director is very appreciative of my work but also another director who appreciates a lot of what I do, and has given me ALOT of tasks to do, because the tasks what I do, uhm, I do it with perfection. . . . (p. 13).*

In relation to feeling appreciated and valued, Andile spoke about how much his daughter meant to him and how her appreciation was 'perfect' and that there was nothing better than that. He went on to explain that through his daughter he began helping others again and making an impact in his environment, which he had previously 'lost' because of his depression.

Andile*:* [when asked what had changed for him] *I think my attitude towards... towards life in general. And I have a... very beautiful daughter. And I think my survival has been through, through her. . . . 'Let's go on holiday with my daughter' -went on holiday, went to Cape Town... uh, a young person telling you she appreciates you - perfect, you know? Nothing, nothing is better than that. And I think when I came back, my focus has just been - I am very selfish when it comes to my daughter. So that on its own has helped me because she would say 'daddy when are we going to do this, daddy this, daddy that', and that kind of love I've also transferred to helping others. I've gone back to coaching, I've started an academy where I, I coach hockey, I give schools equipment's, you know. Uhm, because I also realised that I had an impact in the environment where I played. . . . So those things, I had lost them, the touch I had lost because of depression - but now I've gotten back into it, you know, I've gone back into it. . . . (p. 13)*

Bheka found purpose through his experience of depression and this has significantly impacted his resilience and sense of purpose. He opened his own initiative where men are mentors to one another and meet so that they can speak about their difficulties. Together the

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men share their experiences and normalise speaking about their struggles and being able to express emotions, such as sadness.

Researcher*: And you found it was helpful for you and helpful for them?*
Bheka*: Yes, some of them. I ended up opening an initiative 'Gow su gow' which is, it's man to man - uh a father mentor to a son. Which it's become easy, even now, for us men - we meet and we talk about the challenges we are facing at home, the challenges we are facing at work and the challenges we are facing generally. So even you bring your son, we even talk with them on how to deal with such . . . Because if you check a majority of us blacks, as I've said before - we've been taught that a man doesn't cry. But at the end of the day, a man do cry. Even though he doesn't cry publicly, but you do cry and what you are facing as a lady, uhm, it turns out that we are facing more than what you face. So, it becomes, for you ladies what I've experienced, you guys are able to talk, but when it comes to us it is difficult for us to talk. So, for me to open such an initiative, it becomes easy for whoever that is around me to talk and to face whatever we face (p. 3).*

The initiative had been very rewarding to him because he was able to play a positive role for somebody else and help them to heal.

Researcher*: And rewarding for you? So far, is it rewarding for you?*
Bheka*: For me it is, for me it is. On what we face daily, it's good to see somebody come in with a thing with that sad face but at the end of the day going back home healed so in that way, it's part of me being rewarded - you know what, at least I played a role for somebody, like men in prison - for me to meet the guys, each and every week I meet daily, there are different faces and stuff. For me to get that call after they have been released 'bra you helped me on this day' its [inaudible] (p. 4).*

This initiative has played a significant role in Bheka's recovery – "*So far I am doing good, due to... the initiative, it keeps me busy and... ya... so far I'm doing good. And with the company, the cycle I'm with, its good... I can't complain" (p. 16).* Furthermore, he used the group as a means to educate others within his culture about depression – ". . . *Besides me having the group, and bringing such topics unto the group. So, in that way it becomes easy for them to know that there's a thing we call depression, there's a thing we call anxiety. So,*

the group on its own... the initiative that I started, it helped due to... I'm able to cough it up or to bring whatever that our culture doesn't know about. So, for me to start it, it becomes easy for me to spread the message" (p. 10). Bheka felt that the initiative aided in men feeling supported and raising awareness surrounding men's needs – which he felt were neglected. He has received a lot of interest through his initiative of men reaching out and wanting to share their stories with him.

Bheka*: . . . So, in that way it will be easy for men to know what is happening cause if we check, majority of men, as men, we don't have that much rights. Majority of rights are unto women too much, and campaigns unto women too much, unlike us. So, for me to open up and with the initiative, at least a few men's will be able to open up. Like now in my Facebook, I got a lot of guys in my inboxes telling about their stories and everything. . . . (p. 13).*

Validation and Support: The importance of being heard and collaboration

This sub-theme explores the importance of feeling heard with regards to the participants' recovery. It also explores the relevance of the men working collaboratively with professionals to ensure greater treatment adherence and cooperation from them because they felt validated. The participants' experienced greater success from treatment when they felt they were working collaboratively in the process. Further, they had other people with whom they shared personal experiences with but this was only a select few. Although they were still hesitant to share with most other people, they found it healing to share with the few that they trusted.

Andile described how his therapist fell asleep during his session but it was still helpful because he was able to speak about his struggles. He also described how initially he would accept anything that was advised or prescribed without an explanation but later realised that his recovery was a process.

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Andile*: I only noticed past… the 2 hours because as I opened my eyes he was gone, he was sleeping [laughing]. Ya, so when he came to see me at the hospital… I also felt the institutions are – at the time I felt the institutions are – such a process. Even Dr [*name*], there was a time when the first time he prescribed this is this, this is that, but you know, he wasn't giving me why … you know why do you think you are going through this … why am I prescribing you these pills you know… uhm, but I think the first time you accept anything that's coming your way, honestly speaking. I went out, you always psych yourself out to say 'ey I'm going out, I'm okay, I'm much better', but then I went back into it at some point in 2017 (p. 6).*

With regards to feeling heard, Andile stated that initially he spoke to several people but he would either feel like a burden to them or would be given irrelevant opinions. He started seeing a psychologist which helped him and he was still attending sessions with her at the time of the interview. Andile felt that his psychologist and another man he conversed with were the only people he felt comfortable sharing personal things with and that he preferred it that way.

Andile*: Uhhmm. I , I spoke... okay, I... uhh... I spoke to a couple of people, but some of them were helpless and I feel that, you know I, maybe I spoke to two or three where I felt 'uh ah, I'm just a burden to them, they don't know what to do'. Like I was saying, there'd be - I spoke to a lot of people. Others would want to give you an opinion and it's not even relevant. It's only in 2017, when I met the gentleman that was my psychologist, um his ex-wife is also a psychologist... uh... Dr M*, and I met her and from then onwards I made an appointment almost every month to go and see her and speak to her. And even now I still do, I go and see her, speak and I leave, you know. I don't share much with people. That's what I enjoy now. I listen to people speak, have their opinions, but I never share very close things. There's only one guy I speak to, you know. He also came at the right time as well. He's... uhmm.. uhm.. he does not believe in God but he believed, he believes in in a universe, you know the bigger version, the understanding of, of God, which is the universe. So it helps, such conversations, uplifting. And then the person I'll speak to is the psychologist. Ja. But also I think, she's, she's been very helpful because I've gone through a lot after that. Uhm, not work related . . . (p. 10).*

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Andile went on to describe how he enjoyed conversations with a man he had met through church and stated that him being there physically was another helpful aspect for him while he was experiencing depression – "*. . . Uh, so those are the conversations we started having. And I think what he also did - he's there physically. . . . So if, he's theeereee, physically. And I think that's also a gap that's been there. Where you are able to call somebody and they are there physically" (p. 11).* Andile also reflected on how he has become more aware of how he communicates with others and will refrain from communicating and sharing with others if he feels that he is not being heard.

Andile*: . . . I went this, so I became this, I've became more aware of what happens and how I communicate. And I think some people say, they think 'ay that is too complicated' but I communicate a lot with people and I think.... people will listen to you if they want to and they will hear you if they want to hear you. But uhm, they always say 'ya no, no I'm listening' and they not. So immediately when you don't listen, I don't share, I don't communicate, I don't tell you what I want to see happening, uhm, I just keep it to myself (p. 20).*

Andile concluded by stating that a lot of men were 'time bombs waiting to explode' and that if seeking help was encouraged and men started admitting that they need help that they would be able to address their challenges.

Andile*: . . . and I said to him 'where are you going' and he said 'no, I'm going to see a clinical psychologist' and I said 'that's good'. You know. But you hardly ever get that where somebody says that's good, they say, people say 'ay, it's a sign of weakness'. But its only when men start saying 'I need help', you know a lot of them and that will probably address a lot of these challenges in the work environments. . . . (p. 23).*

Bheka stated that medication was not helpful for him but that writing and speaking to other men and his brother-in-law was – "*I preferred on writing and lucky enough I have a brother-in-law that I can talk to. . . ." (p. 2).*

He also volunteered to run support groups and this gave him a space to share his experiences and allow others to do the same.

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Bheka*: . . . it was outside work because on my spare time it... I volunteered to be part of motivating at B* prison so it was easy for me to cough it up and say what I want to say on that time and be able to show the guys that this is what we are facing in our society and due to cultural to deal with such things because majority, as they are behind bars, some of them are still facing what I was facing but it was difficult for them to share their experience. So, it was easy for them again to have men and men talk so... (p. 2).*

For Bheka, it was important that the person he spoke to was authentic and real in the sense that he felt the world was not perfect and by sharing difficulties with other men it helped them to share their own struggles in a more authentic way. The speaking and sharing was healing for Bheka and helped him to overcome his depression.

Bheka*: . . . Even my spiritual being, cause there was a time that they organised uhm... a session for me and my pastor to talk about everything that was affecting me but it, it's difficult to talk with somebody who never experienced anything, somebody who sees the world perfect and stuff. . . . That's why I ended up finding myself always wanted to be amongst men so that I can be able to cough it and whatever, yes (p. 4 – 5).*

Bheka*:* [in what made it easier to share with his friends] *I realised that some of the challenges I was facing, some of my friends they were facing but it was difficult for them to speak out. So, for me to share with them, it was me to make it easy for them to, to express whatever they are facing in their lives. So, it was easy to share whatever and for some reason I read that to speak it heals, unlike being quiet. Cause the more you are quiet, the more you become bitter and the more you.... you even affect your health cause you always thinking, not even know that you are being depressing yourself (p. 7).*

Bheka concluded by saying that he felt it was important to be heard and to be able to have a space where he can share his troubles. Additionally, he emphasised the value in having someone who would listen without judgement and to work collaboratively instead of a prescriptive treatment.

Researcher*: Okay. Is there anything else you want to add that you feel is important?*
Bheka*: Concerning the depression part.... so far... I don't think there is, besides having... more time with such clients, where you don't have to say much. Just for you to be there, to listen,*

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that's all. Besides that, there is nothing much. Cause at the end of the day, they want to take out what is in them... instead of you telling them what's happening.
Researcher*: Okay, so listening more?*
Bheka*: You listen more, you talk less... so in that way, its better. Like I've said to the male guy, the the psychologist, it was easy for B*, it was easy for me to talk to him cause he was able to, to give me that chance. Sometimes he will even WhatsApp about his life. Even though somehow, somewhere I feel like he lied, but... for him to push me to a point where I'll be able to, to talk to him - it was better. Even the lady, N*, it also helped to a point that... she gave me that time to come and talk to her without her telling me what to do, or what she experienced but just for her to be there - asking me 'what happened? Did you love her? Did you push her? or...' - those are the things that... that is needed. You listen more, you talk less (p. 15 – 16).*

Kabelo had similar experiences to the other participants with regards to feeling heard and working collaboratively. He shared an experience he had with his psychiatrist where he felt discriminated against and dismissed because of his race. However, he did find therapy to be very helpful with one of the psychiatrists he had consulted with.

Kabelo*: Well, it's like the thing is I've always been going to psychiatrists but they don't listen to be honest. And I don't know... cause... I actually had a conversation with one of the guys at work... um, I'm seeing the psychiatrist that he's also seeing. Um, he's a white guy. But... it's like the same person does not treat us... the same way. It's like...... I don't wanna... you know make it a race thing but it's like they can't... it's like I can't explain depression cause... I'm black. It's like 'no, okay I know what's wrong with you, here it is', they don't listen to what you have to say (p. 6).*

Kabelo*:* [On receiving therapy] *Um it was in the hospital with the one lady... it was also... just... pointless. And then I did last year, or the year before last year, I can't really remember, here. There's a lady here, a psychiatrist. And I've been going to her.*
Researcher*: For therapy?*
Kabelo*: Ya, and she actually helped quite a bit.*
Researcher*: Okay.*
Kabelo*: She really did help (p. 8).*

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Kabelo also found healing through talking, although he refrained from talking to colleagues at work because they were 'flippant' about depression. He went on to state that his relationship [romantic] was much better due to him being open and her accepting his diagnosis and this acceptance has made coping significantly easier for him.

Researcher*: So it sounds like the more you speak about it, the more... people open up?*
Kabelo*: Ya, cause the things is it's there, it's really really there but, even now at work I hardly talk about it because... the people just don't get it. Its, you can hear - especially the black guys - you can hear them talking about it and they just flippant about it, like it's something so silly, get over it... move on (p 14 – 15).*

Kabelo*: . . . even my relationship, it's much much better now - like I don't hide anything from her, she knows, cause she'll, she knows she can see me in the morning 'he's in his moods, like whatever'.... and then later in the day I'm back and then she says 'you're back'. So, she just, she doesn't entertain it, it's just something that I do. And like living with people like that... it makes it much much easier (p. 17).*

Kabelo did not find all of his treatment helpful and was particularly frustrated by feeling dismissed and receiving prescriptive treatment. Furthermore, he went on to state that he would appreciate it if the professionals cared, and that this could be expressed by a more collaborative and supportive relationship which includes follow-ups.

Researcher*: Okay so it's just how did you experience the help you received, but I think you've also gone into that. Do you, did you feel that you received adequate care?*
Kabelo*: Well not like... like some of them no, some of them. Like the first guy, yes... the sister no, like she was very very terrible and... some of the guys here, there were quite a few guys that I went to around the Vaal area and they were also not very good. But again, it's that thing of they just dismissive and it's like, they... its... I've heard it before, like take this and then we finished. Ja, like some of them don't even check-up or have... what do you call them... the...*
Researcher*: Like follow-ups?*
Kabelo*: Follow-ups, yes. It's like take it, they give you a 6 months script I'm done. And that's another thing, like when you try to talk back then its 'nah ah' and 'That's not you field'.*
Researcher*: So you want more of a ... like collaborative relationship*

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Kabelo*: Jaaa...*

Researcher*: Where you work together?*

Kabelo*: Jup.*

Researcher*: Okay*

Kabelo*: Like I just wish that person cared... Ja, at what's happening with you after that section (p. 24 – 25).*

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Chapter 5

Discussion and Conclusions

In this chapter, the main summary and findings of the study will be discussed in relation to the research questions. The research aimed to explore the impact of culture, gender and the workplace with regards to depression within this population. The findings revealed that these factors had a profound impact on their experience and expression of depression.

This study demonstrates that culture and gender were strongly intertwined and played a significant role in the experience and expression of depression for the participants. The participants also struggled within their workplaces when they had depression - their ability to work was thus severely impacted which resulted in negative consequences. Furthermore, the participants all struggled with suicidal ideation and two had attempted suicide several times. This was found to be particularly concerning as the participants experienced unrelenting suicidal thoughts. Lastly, it was also important to report on the factors which led to recovery so that we may gain a deeper understanding of what helped the participants in order to be better equipped to assist others and obtain a better understanding of successful treatment within this population. These factors will be discussed and outlined in the sections below.

Experiences of Symptoms and Treatment

With regards to the experience of depression in terms of symptoms and treatment, the findings suggest that the participants were significantly influenced by the expectations placed on them within their gender and cultural roles. These factors impacted on both their symptoms and their help-seeking behaviours. The findings revealed difficulties within their close relationships, struggles with isolation, problematic somatic symptoms, and difficulties at work which led to demotions and job loss. Therefore, they experienced a decrease in physical,

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social and role functioning, as stated in the DSM-5 (APA, 2013). These results were in accordance with the DSM-5 guidelines.

Haroz et al., in Mayston et al. (2020), claim that the most common features in both Western and non-Western cultures included depressed mood or sadness, fatigue, loss of energy and sleep problems, which was corroborated by findings in this study. There were core clinical features which were revealed in the experiences of depression with the participants, and particularly somatic complaints (Austin, 2012). Therefore, the men presented with several criteria from the DSM-5. This included low mood and anhedonia, a change in sleep patterns, psychomotor changes, loss of concentration or indecisiveness, loss of energy, guilt feelings or loss of self- esteem and suicide ideation or suicide attempt (Baumann, 2015; Dowrick, 2004). However, changes in eating habits and loss of libido were not mentioned by the participants. Other common features which are not included in the DSM-5 included social isolation, crying, anger, and general pain (Mayston et al., 2020). The participants all experienced significant irritation, anger, and isolation which profoundly influenced their experience of depression by exacerbating their symptoms. Delays in treatment resulted in all of them experiencing severe impairment in their functioning, and two of the participants being hospitalised for their depression. There were several causes identified for this delay in treatment.

World Mental Health Surveys conducted on help-seeking behaviour for mental disorders revealed that in South Africa only a quarter of the respondents with severe CMDs had accessed any form of health care for their mental health problem in the previous 12 months and two-thirds of the treatment seekers sought help within the non-specialist sector (Akyeampong et al., 2015). The length of time between the onset of depression and receiving care with regards to their depression was unknown, however, it was revealed that the participants were unaware that they had depression for some time. The participants spoke

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about how they had presumed that they were stressed, as they had experienced overwhelming pressure either from work or from other situations, and they felt they could cope and it would pass. When the severity of their somatic symptoms increased it led them to seek help from a General Practitioner (GP).

The participants all initially sought help for their somatic symptoms from a GP and through the course of treatment, they had all attempted medication and been to a psychologist, psychiatrist or counsellor. This implies that GP's were the first point of contact within this population. This is significant in understanding the initial manifestation of symptoms and problems, as well as the help-seeking behaviour within this population.

The participants displayed somatic discomfort and loss of energy as presenting complaints, in line with other literature regarding culture (Akyeampong et al., 2015; APA, 2013; Austin, 2012). Further, the APA stated that with regards to culture, insomnia was likely to constitute a presenting complaint (2013). Insomnia was not confirmed to be the presenting complaint within this research, only one participant complained of this with onset. Findings revealed that all of the participants complained of feeling physically unwell, lack of energy, or an inability to concentrate, and several factors impacted this.

Studies in Africa found that emotional and cognitive experiences may not be readily volunteered to treating health care providers (Akyeampong et al., 2015). The participants in this study did not complain of emotional experiences to their GP's but they did disclose somatic symptoms. This may be due to depression being unknown or that it was culturally unacceptable for men to portray signs of weakness, such as sadness and crying with regards to emotions. Akyeampong et al. (2015) state that depressive symptoms were related to thoughts rather than emotions and that an appropriate solution was to seek lay help from social groups. Findings showed that concerned families and communities sent them to get help from

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religious organisations and by traditional means, such as traditional healers. This treatment was unsuccessful for the participants, who preferred to follow the professional route for treatment.

All three of the participants were concerned about and against the negative side effects of medication and preferred talk therapy. Only one participant continued with medication combined with therapy. There seemed to be an element of control that the participants wanted and the pharmacological side-effects seemed to interfere with their sense of control. The participants felt that speaking about their difficulties was particularly beneficial because they felt they had more control and agency within the process. Findings further implied that male therapists may be more effective in assisting this population, as the participants identified more with individuals of the same gender. This may be due to the influence of culture on their expression and interpretation of emotions or difficulties, which was a significant finding within this research.

Depression and Culture

The findings indicated that the interplay between culture and depression was prominent and had a significant impact on the participants' experiences of depression, their willingness to seek help, and during their recovery process. The participants had struggled with expectations placed on them with regards to providing and doing what was expected of them within their familial and cultural roles. Furthermore, when they were diagnosed with depression it was not known or understood within their cultures and they were not supported.

Literature states that in many languages, there is no equivalent for this concept [depression] and it remains diffuse and undifferentiated (Dowrick, 2004; Ellis, 2008). This study confirmed that in African culture and language, mental health concepts were not familiar (Van Niekerk, 2016). Depressive symptoms were thought to be stress-related. The

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participants all initially tried to manage their depression on their own and were not aware of depression and believed it would resolve on its own without assistance, as was stated by Andersson et al. (2013).

There was evidence that the participants' cultural background influenced the ways in which they experienced depression from linguistic structure to uniquely expressed emotions (Awaad & Reicherter, 2016). In the literature review, it was found that an important aspect of understanding psychopathology according to culture is the psychoplastic effect, whereby culture influences the expression of psychopathology (Wagner & Hassim, 2013). This was confirmed in this study as the participants felt pressure and expectations in their roles as African men. Furthermore, they felt that they could not speak about or express their troubles as it was not acceptable and they may be seen as 'weak'. After receiving their MDD diagnosis, they described that their depression was initially not accepted within their cultures and they were rejected or perceived to have a problem with their attitude. Furthermore, they described how they had wanted to share and speak about their struggles but felt that they had little resources and that no-one would listen or accept that they were struggling. Findings further revealed that they were told to be strong and get better on their own, to the point where one participant described this inner turmoil as 'being cursed'. This experience had definite consequences on the manifestation of depression and exacerbated their depressive symptoms. They were further isolated and rejected, which also implied that they had no support with regards to their depression. In a systematic review across studies, Gariépy, Honkaniemi, and Quesnel-Vallée (2016) found that there was a significant association between social support and protection from depression among adults.

With regards to the concept of depression possibly being meaningless in some cultures and languages, as well as mental health being largely Westernised, (Ellis, 2008; Dowrick, 2004), this was not necessarily the case within this population. When the participants had

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been diagnosed and had gained an understanding of depression, they were accepting of their diagnosis and did not reject it due to it being a Western concept. It should be noted that the participants were young adults and their families and elders were not initially as accepting as they were with regards to their diagnosis.

With regards to African culture understanding mental health and disorders in spiritual ways and ascribing the causes to external forces such as social conflict, envy, witchcraft, or sorcery (Austin, 2012), the participants themselves did not express this. Nor did they refer their feelings of sadness or distress terms such as having a "heavy spirit", "difficulty breathing" or being oppressed by others (Baumann, 2015). However, within their cultures, the findings suggested that members of their community still expressed these attitudes and that it may still be quite prominent. Because some family members or community members would ascribe mental illness to witchcraft or Satan, religious and spiritual practices would be utilised to assist those in distress and failure thereof resulted in rejection from the community. The participants expressed that cultural beliefs exacerbated their depression and forced them further into isolation and in trying to manage their depression on their own. Findings also revealed that through their recovery process, their family members and communities became more accepting of the diagnosis, which helped them to overcome their depression.

Wagner and Hassim (2013) stated that culture is environmentally acquired and reflects societal experiences conveyed cross-generationally. The participants expressed that some of the older generations were open to learning and accepting new concepts into their culture, such as depression, for the benefit of people. The findings suggested that this was true even in individuals who would accept a condition they did not necessarily understand. Furthermore, the participants felt that this responsibility should fall on the younger generations who were exposed to more concepts. The participants had already begun this process by speaking about depression and creating awareness through support groups and dialogue within their

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communities. The participants further expressed that awareness and education about depression should be done in order to help others who went through similar experiences.

Therefore, cultural factors seemed to have a significant influence on the way depression is experienced and expressed by African men. Additionally, being a man in African culture indicated that there were certain expectations placed on them, such as not expressing sadness or crying, which delayed their recovery and exacerbated their depression. The findings suggested that the participants felt cultural transition needs to happen [balance between Western and African cultures] and that men should focus on communication because the lack of communication was causing depression. It should be noted that the participants did not share with everybody but only with those they trusted. They remained guarded and cautious with sharing due to the stigma of mental health difficulties. Other studies done in South Africa have confirmed that there is stigma surrounding the mentally ill (Hamad et al., 2008). Findings also revealed that the participants felt that they were treated differently from women in their culture, where women were free to discuss their troubles and express their emotions, it was not acceptable for men to behave in the same way.

Depression and Gender

Due to the gender implications of being African men, their experiences and expressions were further influenced by these societal expectations placed on them. Findings revealed that the participants struggled to reach out for help and battled to find ways to cope on their own. In attempts to cope with their depression and in addition to the isolation, they all abused alcohol to manage their symptoms. Findings showed that they felt unequal and unfairly treated when compared with women and expressed a need for care and to be heard. Furthermore, due to the pressure they felt as men, they kept their depression to themselves for a long period of time and only received help when the suicidal ideation or suicide attempts

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were imminent. This resulted in the participants struggling with their depressive symptoms alone and exacerbating their depression for a significant amount of time before getting help.

The men were under pressure to provide for their families, as was expected within their culture by being a man. In a study conducted by Bantjes et al. (2018), it was found that symptoms of depression were significantly associated with having financial dependents and socio-economic stressors. The findings revealed that the participants felt pressure to work and that the emotional support of their families would have had a positive impact on their recovery and well-being. Family support was found to be a protective factor against depression in adults (Gariépy et al., 2016). The findings also suggest that the rejection they faced prolonged their recovery and exacerbated their symptoms.

The findings of this study confirmed that men may not present with typical depressive symptoms and that it was difficult for them to reach out for help. The participants were more prone to express emotions such as anger. They all struggled with noticeable anger and irritability, with some participants expressing anger outbursts and a negative impact on their relationships as a result thereof. Additionally, all of the participants abused alcohol to manage their depression. These symptoms are in line with the literature which claims that men were likely to express anger, irritability, substance abuse, and risk-taking behaviours (Kunst et al., 2019; Martin et al., 2013). The findings of alcohol abuse were particularly concerning within this research as it has far-reaching consequences.

Alcohol abuse and MDD often co-exist and this can have significant implications for patient functioning and prognosis, further, MDD may lead to people ‘self-medicating’ (Sher, 2009). Lund reported that men had twice the risk of substance abuse when compared with women (Bateman, 2015). Of concern in the findings was that all of the participants became reliant on alcohol to manage their symptoms and cope with their depression, despite the

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negative consequences as a result thereof. Individuals with major mood disorders are at an increased risk of having comorbid disorders such as alcohol abuse or dependence which may worsen the prognosis of the illness and increase the risk of suicide (Sadock et al., 2016). Research on the comorbidity of MDD and alcohol abuse has largely been conducted in developed countries with little research being conducted in developing countries (Sher, 2009). These two factors combined with the findings of this study indicate that this should be explored further within this population and South Africa.

Alcohol usage poses a threat to the quality of life of South Africans and alcohol abuse can directly or indirectly impair people's lives - not only on individuals, but on familial, societal, and national levels (Pisa, Setlalentoa, Loots, Ryke, & Thekisho, 2010). Additionally, there are indications that the African population in increasingly prone to alcohol dependency due to abuse (Pisa et al., 2010). The findings suggest that the participants abused alcohol in order to cope and this further impaired their ability to function. The findings also suggested that being a man affected the participants in that they felt unable to seek help with their depression and used these methods in attempts to cope in isolation and thus remaining congruent with ideals of masculinity.

This study corroborated the findings from other studies, which claimed that men were less likely to report their symptoms because the symptoms were at odds with ideals of masculinity and social constructions of gender roles (Martin, 2010; Martin et al., 2013). The participants in this study felt that their depressive symptoms were a sign of weakness and they were encouraged to 'be strong'. The findings suggested that they were initially rejected when they could not cope alone and did reach out for help. This has far-reaching implications because the participants were further isolated in their experiences and this exacerbated their symptoms and prolonged their recovery. Findings indicated that the participants had tried several other methods to cope with their depression on their own. Two participants tried

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exercise and routine to cope, but this was only helpful to a certain degree and was not effective in treating the depression.

The implications that the participants could not share their distress and depression with anyone, despite strong desires in wanting to do so included emotional suppression. Emotional suppression is an important factor in male depression and given the stark contrast between depressive affect and cultural norms of masculinity, suppression may be a consequence of their depressive symptoms as they try to avoid rejection for being unable to be 'manly' (Flynn, Hollenstein, & Mackey, 2010). Not being able to speak about their experiences was identified as one of the critical points in this study. Not being able to share, as well as judgement and stigma, and not having a 'visible' illness, had a significant impact on the severity of the depression and the coping ability of the participants.

The findings confirmed that men may be hesitant to disclose their symptoms in order to conform to cultural gender roles and societal standards. Further, that there were altered ways in which men experienced and expressed their depression. The participants were judged and criticized when they tried to seek help within their communities. Findings suggested a similar experience within their work environments, which were experienced as unsupportive.

Depression in the Workplace

The impact of depression within the workplace was found to be significant. The participants in this study felt overwhelmed at work and felt that they were given ineffective assistance with regards to their depression. Furthermore, findings showed there was a reciprocal relationship with regards to their depression and workplace.

The participants had demanding work roles, and together with environmental stress, became unmanageable and compounded their depression. Although findings did not reveal the exact triggers of their depression, Stockenstroom stated that occupational stress could

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trigger depression (2018). Two of the participants struggled with stress at work which preceded their depressive episodes. Some of the participants were also unaware that their work-related stress was becoming unmanageable. Findings revealed that all of the participants struggled with occupational stress which exacerbated their depression. Occupational stress symptoms did not occur in isolation and there were other factors which caused the participants stress. Ahmed and Bhugra (2006) stated that environmental stress could predispose individuals to depression. The participants became overwhelmed with various stressors and this possibly contributed towards triggering their depression. The negative feedback received as a result thereof further added to their stress and depressive symptoms.

Findings revealed that the participants were unable to function at work and all of them spoke about an impaired ability to think or concentrate which negatively impacted their performances, these findings were in line with what was stated by the APA (2013) and Sadock et al. (2016). Further, the participants in the study stated that they would isolate at work and be physically present but not engaged, only performing the bare minimum required at work. Findings indicated that they were, therefore, not functioning optimally within their work environments. This ultimately led to an inability to work (two participants were hospitalised), suicidal ideation was experienced by all of the participants, as well as demotions and job loss, as was proposed by Woo and Postolache (2008). In addition to this, findings indicated that the participants took time off from work to cope with their depression.

Prof. Crick Lund of the Department of Psychiatry and Mental Health at UCT stated that the figure for people to experience an inability to work or conduct day-to-day activities is an average of 27 days per year for depression (Bateman, 2015). The findings from this study indicated that the participants would frequently take time off for their depression and get sick notes, the duration thereof was calculated as months at a time. Findings suggest this is a significantly higher loss of work days than was stated by Prof. Crick Lund. If depressed

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individuals took months off of work at a time, this would have severe consequences on individuals, companies, and the country's GDP.

Lastly, findings revealed that the participants did not feel comfortable in disclosing their diagnosis at work and the reasons for their sick leave. Stander et al. (2016) stated that non-disclosure of depression as a reason for sick leave was predominantly due to stigma and work security issues. Findings revealed that the participants experienced significant stigma in the workplace combined with a lack of confidentiality, which made it difficult to share their experiences at work. Findings further indicated that stigma and lack of confidentiality exacerbated their depression because it isolated them and created barriers to recovery. The findings suggested that it was unsafe to disclose their depression and stressors to their managers or bosses due to lack of confidentiality and as well as a threat to their job security.

The study done by the South African Depression and Anxiety Group, showed that a significant proportion of respondents believed that their employer would not know how to support them (Stander et al., 2016). With regards to support within the work environment, none of the participants felt that they were supported or given adequate resources to cope. The counselling centres and structures in place to assist with mental health difficulties were found to be ineffective. Findings revealed that the participants felt that the procedures in place were prescriptive and treated as 'check lists' to follow within the company.

In concluding workplace and depression, it was found that although there were resources available to the participants at their respective companies, they felt that they were in place as part of company procedures and were not effective or adequate. They felt that their bosses and managers were not able to assist them and would not keep their depression or difficulties confidential. In addition to this, stigma was found to be of concern within workplaces and mental health difficulties were generally not accepted or tolerated. This

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caused further stress on the participants and compounded their depression, which included suicidal ideation.

Risk of Suicide

An alarming aspect from the findings of this research was the suicidal ideation and attempts from the participants. Two of the three participants had attempted suicide on more than one occasion, and all of them struggled with continuous and unrelenting suicidal ideation. Their experiences were congruent with the APA's findings which stated that untreated depression may lead to attempted or completed suicide (2013). The possibility of suicidal behaviour was experienced at all times by the participants and they were at higher risk due to the history of suicide attempts, being male sex, being single or living alone, misusing alcohol, and feelings of hopelessness (APA, 2013; Isometsä, 2014). The men all fell into the highest risk category in South Africa (being males aged 15 to 44 years) (Kootbodien et al., 2020). Furthermore, it should be noted that alcohol intoxication increases suicidality and especially when related to depression (Silke, 2018).

With regards to the severity of the participants' experiences, they fell into the severe range of having a suicide plan and experienced a constant painful emotional state and did not want to be a burden on others (APA, 2013). Findings showed that the participants struggled significantly with their suicidal ideation and one participant stated that any added stress would trigger him into thinking he would be better off dead and claimed he felt envious of the deceased. The overwhelming pressure that the participants felt led them to believe that suicide was the way in which to escape their difficulties. The two of the participants, who had acted on their suicidal ideation and attempted suicide, spoke about the ways in which they would think about completing suicide by using methods available to them at work – such as poison or car accidents.

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The most common methods of suicide in South Africa were reported to be hanging and poisoning (Kootbodien et al., 2020). This could be partially confirmed in this study as two of the participants expressed that they would use poison to complete suicide (overdosing on medication and using poison available at work). One participant expressed that he tried to complete suicide by making it look like a car accident so as to preserve his pride and protect his family, had he been successful then the reason for death may not have been suicide. This has significant implications for this research because if African men are more likely to make their suicide look like an accident, we may struggle to get an accurate reflection of the numbers of suicide in our country, which may be significantly higher. Underreporting of suicide has been noted, and suicide may not be reliably counted or documented on death certificates in South Africa (Akyeampong et al., 2015; Kootbodien et al., 2020). Globally, suicides and suicide attempts may not be correctly classified but looked at as accidents, such as with car accidents and poisoning, and the WHO suspects that underreporting ranges between 20% and 100% (Silke, 2018).

With regards to the participants, there were several reasons why they decided to not complete suicide. Findings revealed that the reasons ranged from their children and caring for their families or concern over how their families may process the suicide. Other reasons included that they did not get the opportunity to commit suicide and there had been some instances where events and situations interfered with their plan to commit suicide. The participants also felt guilt with regards to their suicidal ideation and attempts, with one participant interpreting his injuries from accidents as punishment for wanting to die. Findings showed that the participants struggled with suicidal ideation and there was a significant chance that they may have been successful in their attempts. This is essential to address within these populations so that we may decrease the probability of suicide within South Africa and

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preserve life. In order to do this, we need to have an understanding of what can be utilised to assist this population in their recoveries.

Factors Linked to Recovery

An important finding within this research, which is connected to the research question, are the factors which contributed to the recovery of the participants. These findings will enable us to understand how we might be able to assist other depressed individuals within this population. It was evident that the participants all experienced a great amount of difficulties and struggles on their roads to recovery. They had initially assumed that their recovery would be a 'quick fix 'and not the journey that they were led unto.

Findings showed that the concept of individuation seemed to play a significant role in their recovery from depression. Individuation, as defined by Jung, is the process of differentiation from the norms and the values of the society in which a person is immersed (Tricarico, 2016). When the participants had accepted their diagnosis and begun the recovery process, much of it included creating a new sense of self. The participants had decided what worked best for their identity, in a sense recreating their identity, and they conformed less to the cultural and societal expectations placed on them. This shift within their identities and attitudes contributed towards their recovery as they experienced an overall more satisfying life and general well-being by prioritising and attending to their needs in addition to others. This allowed them to be in a better position to combat stressors and care for themselves. The result was that they now lived a life with more independence, purpose, and fulfilment, which gave them a new sense of self.

Findings also showed that the more they learnt and understood depression, the better equipped they felt in the management and recovery thereof. The participants did not want to be dependent on anything but rather have the freedom to choose and be able to rely on

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themselves and find what worked for them based on their needs and this sense of agency was important to them. The participants all found therapy or counselling to be helpful and this process enabled them to have agency.

Findings revealed that a significant concern for the participants was that people do not speak about their problems and this had several negative consequences. Further, that men should be encouraged to share and admit when they experience difficulties or depression so they could be in a position to recover. It was also raised that men's needs were not being addressed and they felt neglected within their communities. Within their communities, the men had begun talking about their struggles and creating awareness surrounding depression. Their relationships had become more open and with other people accepting their diagnoses, it made coping significantly easier and aided in recovery and maintenance. One of the participants had started an initiative whereby men could get together and share their difficulties and have a space to share and express emotions such as sadness, which was allegedly very successful. With regards to prevention and treatment, an important finding in this research was that more awareness and knowledge regarding mental illness needs to be conveyed within communities.

All of the participants valued feeling appreciated. Two of the participants found purpose by helping others in similar situations with regards to depression. These factors contributed significantly to their recovery, overall sense of self-worth, resilience, and added meaning to their lives. With regards to work, appreciation was also an important factor in the well-being of the participants and this motivated them to perform better. It may, therefore, be an important aspect of recovery that South African men feel appreciated, validated, and have a sense purpose.

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With regards to validation and support in treatment, the participants found it important to work collaboratively with professionals, which ensured greater treatment adherence and cooperation. Although all of the participants initially struggled to find a professional or someone they could work with, they all found great value and relief from their depression by speaking and sharing. It was important for them to have a space to share and be heard without judgment and by working collaboratively. The participants did not respond well to feeling dismissed or receiving prescriptive treatment. One participant expressed that a more collaborative and supportive relationship could also include follow-ups from professionals. These findings imply that this population may have more success in the treatment of depression through psychotherapy, as opposed to medication, and that within these therapeutic relationships collaboration and personal agency were critical to the outcomes of successful treatment. At the time of the interviews, they were doing significantly better both within their work and personal lives.

Limitations

Limitations linked to the current study include the small sample size due to the nature of qualitative research, which may not be generalizable to the population. A larger sample size may have made the findings more valid with regards to this population. Additionally, the participants all belonged to an African culture and although there are similarities within these cultures, African culture is diverse within South Africa. Each participant within this study belonged to a different African culture, which may have had an impact on their experiences of depression. Lastly, the participants were employed in different positions within their work environments, which may have uniquely contributed to their experiences of depression.

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Recommendations

There are various recommendations for future research related to this study. Firstly, when conducting future cultural research in South Africa, it is suggested that participants of the same culture are investigated as their experiences of depression may present with unique aspects thereof. Although there are similar traits in African culture, each culture has its own unique traditions and societal expectations and this may influence the experience of depression differently.

Secondly, depression within this population should be more widely explored and researched. It is clear that there are cultural and gender aspects which impact this population, and to date, little research has been conducted within this population. Suicide is one of the major concerns within this population and the figures we have are likely underrepresented.

Thirdly, another aspect of depression within this population is the tendency for this population to abuse alcohol in attempts to manage their depression. This resulted in negative consequences, exacerbated their depression, and increased the likelihood of suicide. There is little research being conducted on the comorbidity of MDD and alcohol abuse in developing countries (Sher, 2009). This would, therefore, be essential to investigate so we may address these issues and concerns.

Fourthly, depression in the workplace needs to be addressed. This could include companies being more sensitive towards confidentiality and the rights of employees. Training programs can be included which may reduce stigma in the workplace and create more awareness surrounding mental illness. Time off due to depression was another significant finding in this research and the length thereof can be investigated more so we may gain a better understanding of the impact of depression in the workplace and by a greater extent, on the country's GDP.

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Lastly, there seems to be a desperate need to address the mental health of men in this country and to create spaces where men can share and express their difficulties, concerns and troubles in order to assist in alleviating and preventing mental illness within this population.

Conclusions

In concluding this qualitative research study with regards to the experiences of depression within this population, there were several factors to consider which impacted one another. The study revealed that this population may present with somatic symptoms, some DSM-5 symptoms, and additional symptoms, such as anger, alcohol abuse, and isolation. Culturally, depression was found to be an unknown concept. The concept of depression was not rejected by younger generations but instead, they showed a willingness to transform or adapt culturally with regards to mental illness. Findings suggested that this population faced significant amounts of stress within their communities and in their workplaces with regards to the expectations placed on them. Furthermore, they felt that they could not share their difficulties with others and that stigma and rejection was quite prominent. These expectations and factors exacerbated their depression which resulted in suicidal ideation or attempts and prolonged their recovery.

It was also identified that a GP was the first point of contact with regards to treatment and that talk therapy was the preferred method of treatment and not medication. Furthermore, that this population may benefit more from a collaborative therapeutic relationship with an individual of the same gender and which allows a significant amount of personal agency within the process. The findings indicated that there was a longing and need for this population to have a space where they felt heard and could express themselves. The study also found that the support and acceptance from their families, communities, and workplaces played a vital role in their recovery and well-being.

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With regards to the workplace, a reciprocal relationship with regards to depression and the workplace was identified. The work environments were found to be unsupportive and the procedures in place ineffective and procedural, rather than curative. Lack of confidentiality and stigma were further significant findings that exacerbated depressive symptoms, hindered help-seeking behaviours, and prolonged recovery. There were negative consequences of depression within the workplace which included demotions, job loss, sick leave, and hospitalisations. There were reportedly large amounts of leave accumulated due to depression and this has an impact on both the company and country's GDP. Should companies find more effective means of addressing these hindrances, they may suffer less negative consequences. One of the measures that can be implemented to reduce suicide rates are community awareness programs, which can be implemented at workplaces to increase knowledge and reduce stigma (Silke, 2018).

In summary, the impact of depression has far-reaching implications. The results of this study may not be generalizable to the larger population due to the small sample size, however, significant findings were identified within this research which may impact our understanding of depression within this population, and considerations with regards to treatment and recovery were presented. Furthermore, the study identified crucial gaps in literature and the lack of research conducted within this population. All of the participants reported that they were currently significantly more productive and coping a lot better since recovering from their depression. This implies that depression is an important issue to address within this population.

Researchers Reflection

As previously mentioned, I am a curious person by nature and became interested in this topic when I was made aware that mental illness may manifest differently with regards to

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culture, and I felt it was an important topic to investigate. Additionally, my curiosity and concern was further ignited by being exposed to numerous news reports regarding the suicides of black men and by being exposed to various campaigns in raising awareness about depression in South African men. Furthermore, being involved in the mental health field within multicultural South Africa, I believe it is essential for us to investigate the experiences of diversity within mental illness.

A question which I had to face on numerous occasions and from various individuals, was my reasoning behind this research. As a white female in South Africa, I was aware that there were both gender and cultural differences between myself and my participants. I was also aware of the cautions that I would struggle to find participants and that black men did not speak about depression. This did create some doubt in my ability to conduct this research as I struggled to find participants. The belief that this research was important and worthwhile kept me motivated and determined - through persistence and spreading awareness, and with the help of others and organisations, I was able to find participants.

When I met with each participant, I did wonder whether they would be comfortable in being vulnerable and engaged. My concerns were put at ease when I interviewed each participant and was able to establish rapport, the men openly shared. It was perhaps by being a different gender and culture, and by being a psychology student, which assisted in putting the men at ease because I could listen and they could engage without fear of judgement as African men because I was openly curious and did not presume to know what it meant to be an African man with depression. I did not feel there was resistance from their side as they seemed very open and seemed to appreciate the opportunity to share their experience. This was also a strong theme within my research, that black men wanted to be heard and validated, and this research further allowed that. I listened to their experiences with curiosity and openness during the interviews and gently probed when I did not clearly understand

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something they said. There was one participant who at times struggled to articulate himself in English, and I managed this by gently probing and allowing him the space to explain what he had meant. I have a psychology background which is based on certain assumptions regarding the DSM-5 and depression, I was careful to try and bracket this off during the interviews and allow the participants to share.

Perhaps the most daunting aspect of this research for me were my concerns regarding capturing the essence and understanding of what the participants experienced. I interpreted the results to the best of my ability, fully aware that I am a novice researcher in IPA. I appreciated the participants' openness and willingness to share their experiences and as such, I spent great lengths of time carefully going through the data and analysing the findings. I interpreted the results by using my background in psychology, experience in diversity, and, to the best of my ability, by removing my subjective interpretations.

I believe limited studies within this population and the challenges thereof further endorse the need to conduct research within this population. This was an interesting journey for me and has enhanced my knowledge and understanding of individuality and diversity even more. The results of this research have the potential to further our understanding of depression within this population and I am grateful to have been a part of it.

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Appendix I

Faculty of Humanities
Department of Psychology

Consent Form: Research Participant

Title of the study:

"Experiences of depression in black South African young adult men in the workplace."

Purpose of the study:

The study aims to investigate the experiences of depression amongst black South African young adult men in the workplace in order to explore how gender, culture and the workplace influence help-seeking and the experience of depression.

Procedures:

The participant and researcher will select a time and venue where an interview can take place. The interview will be approximately an hour and it will be recorded. There are no expectations of the interview, the aim is to connect and hear your story. The recordings will then be transcribed for analysis.

Risks:

The interview may become uncomfortable or cause discomfort due to the personal nature of the research. The researcher will be sensitive and understanding to this. Free psychological services at a clinic in the Pretoria area will be provided if necessary as well as referrals to Lifeline or SADAG if requested.

Benefits:

There are no monetary benefits to participating in this study. The study will benefit others in that a better understanding of depression and how it is experienced in black South African males will be attained and this may assist with helping them and the well-being of others. It will also contribute to African cultural and gender experiences of depression.

Participant's rights:

Participation is voluntary. You may withdraw from this study at any time without negative consequences.

Confidentiality:

All information will be treated as confidential and anonymity is assured. Should you withdraw from the study, your data will be destroyed. Only authorised individuals will have access to data.

*** Should you have any query or concerns, you may contact me, Roxanne Zwart, via e-mail on u28332386@tuks.co.za or my supervisor Dr Linda Eskell-Blokland on linda.blokland@up.ac.za**

R. Zwart (Researcher)
PSIN 0152765
Date: ______________________
Sign: ______________________

Participant Name:
____
Date: ______________________
Sign: ______________________

Fakulteit Geesteswetenskappe
Departement Sielkunde
Lefapha la Bomotho
Kgoro ya Saekolotši

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Appendix II

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University of Pretoria
Department Of Psychology
c/o Solomon Mahlangu (Hans Strijdom) & Hinterland Street
Mamelodi East
Administration Building
Ground Floor

Tel: 012 842 3515
Fax: 086 551 6828
E-mail: itsoseng.clinic@up.ac.za

NATIONAL LOTTERIES COMMISSION
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Clinic Hours
Mon – Thu: **09h00 – 16h00**

CONFIDENTIAL

To whom it may concern,

This letter serves to provide permission to Roxanne Zwart, ID number, to refer research participants in the study – "Experiences of depression in black South African young adult men in the workplace" - to Itsoseng clinic who may experience distress as a result of their participation in the research. These participants will be seen as high priority clients and to be assisted as soon as possible.

Please do not hesitate to contact us for any further information.

Itsoseng Clinic
University of Pretoria
Mamelodi Campus
Cnr. Hinterland & Solomon Mahlangu Drive
Mamelodi East, Pretoria
Tel: 012 842 3515

Rico Visser
Clinic Manager

07/11/2018
Date

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Appendix III

Faculty of Humanities
Department of Psychology

2019

Invitation to participate in research:

Experiences of depression in black South African young adult men in the workplace

How do black South African young adult men experience depression in the workplace? Research shows that depression affects one in four people in the workplace. There is limited research on the experiences of depression in black South African men.

The aim of the study is to investigate the experiences of depression in black South African young adult men in the (South African) workplace in order to explore how gender, culture and the workplace influence the experience of depression.

Criteria to be participate:

- **Black South African male**
- **Aged approximately 24 – 44 years old**
- **Previous diagnoses of depression from a healthcare professional (i.e.: a doctor or psychologist) and not currently experiencing a depressive episode**
- **Fluent English (Comfortable to converse in English)**
- **Active in the workplace**
- **Based in Urban Gauteng area**

I am in the process of recruiting participants to be a part of this study, please pass on to anyone who may be interested. My aim is to connect and hear each person's story. Please contact me with regards to eligibility or for more information.

Please share if you know people who might be interested in this study.

For more information please e-mail me, Roxanne Zwart, on u28332386@tuks.co.za or my supervisor Dr Linda Eskell-Blokland on linda.blokland@up.ac.za

Humanities Building
University of Pretoria, Private Bag X20, Hatfield 0028, South Africa
Tel: +27 (0)12 420 XXXX
Email: name.surname@up.ac.za
Web: www.up.ac.za/psychology

Fakulteit Geesteswetenskappe
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